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Culture Stories: The Narrative Metaphor in Postmodern Therapeutic Practice

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Culture Stories: The Narrative Metaphor in Postmodern Therapeutic Practice by David Paré in partial fulfillment of the requirements of Doctor of Philosophy in Counselling Psychology.

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To Susan, Casey, and Liam

Abstract

The three essays collected here reflect facets of a growing body of therapeutic thought and practice informed by the postmodern debate. The first essay deconstructs the classificatory language of diagnostic psychiatry through an examination of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The author describes how a taxonomy founded primarily on deviance from a statistical norm leads to the view of differentness or uniqueness as pathology--a perspective with oppressive implications for any who do not adhere to or exemplify normative ideals. The second essay looks at the use of the narrative metaphor in therapy with persons who abuse. The author argues that most established psychotherapeutic traditions have great difficulty contemplating issues of intention, choice, and agency because they are founded on natural science-informed metaphors. Within such a paradigm, one is inclined to view abusive behavior as the symptom of an underlying pathology (in the tradition of medical science) which must be treated. The essay explores a paradigm founded on a narrative metaphor which offers an alternative frame for viewing and working with persons attempting to shed their abusive ways. The essay concludes that the narrative metaphor brings forward the moral dimension of therapy by construing persons as agents of their own choices. The third essay reflects on the place of knowledge in the therapeutic encounter. A distinction is drawn between law-based versus culture-based knowledges. Law-based

knowledges are seen to construe families and individuals as specific instances of general principles. This tradition is regarded as akin to racism in that it involves the imposition of one culture's meanings (ie. the professional culture of therapy) on another's (ie. the family or individual). Culture-based knowledges are identified with a historical/narrative tradition which emphasizes the uniqueness of each context, and grants primacy to the client(s)' story, an instance of local knowledge. The author proposes that by adopting a culture-based view of knowledge, clinicians may make room for their own "expertise" without inadvertently subjugating the knowledges of their clients.

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The work contained here is the product of several years of intensive study of some challenging ideas and practices--an adventure undertaken with the steady guidance of Don Sawatzky. Thank you, Don, for encouraging me to author my story.

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My brother, Tim Paré, and my brother-in-law, Chris Peet, have been intellectual companions on this journey, and have boosted my morale many times with our lively philosophical explorations. Thanks for the conversations.

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Finally, thank you to my children, Casey and Liam, who are my best reminders of the beauty of each story, and the preciousness of life.

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Table 4-1: Distinguishing Features of Law-Based versus Culture-Based Views of Knowledge

CHAPTER ONE:

Introduction

Some nine or ten years ago I was halfway through a hot shower when it struck me that I could switch careers. I could quit my job making educational television programs and re-visit the communal conversation called academic psychology--a conversation which had so engrossed me as a college student, and then a university undergraduate. The realization unstopped a torrent of images of myself as a practicing psychotherapist, a trainer of therapists, a published writer.

If those images had been captured somehow at that time, and compared to the place I now find myself, the discrepancies would be startling indeed. I train; I write; I am a working therapist. But my journey back to the ideas and practices of psychology has introduced me to territory I never expected to visit. I had anticipated that I would become expert in the workings of the mind and the heart, a sort of self-realized sage with a substantial understanding of the nuances of my own psyche. Instead, my travels have taken me in more of an outward direction. The psyche I sought I have found in the communities I inhabit, reflected in our cultural traditions and institutional structures, and in the stories they bombard us with through our hyperactive media. I have come to see what goes on "inside" my head and heart as a mirror for the collective meaning-making I share with all those who co-inhabit this planet. It has been an unanticipated and humbling discovery.

Out of that discovery has emerged a sensibility of a very different character than my shower-warmed fantasies of personal mastery and professional expertise. I almost bask in my ignorance now (finger hovering over the *delete* button as I reflect on the incongruity of this comment in a doctoral dissertation). This does not mean that I have learned nothing. Instead, I think it reflects the very different-ness of the place I now find myself when I reflect on my earlier images of the doctoral candidate on the cusp of graduation. My sense of what a therapist-in-training "learns" has changed immensely.

I have come to believe that being an effective therapist has a lot less to do with what we "know" and a lot more to do with how we position ourselves relative to our clients. For example, it now

appears to me that a genuine show of *respect* is a far more admirable therapeutic intervention than the most esoteric of clinical sleights-of-hand. This conclusion follows on a great deal of reading and conversation, practice and soul-searching. It grows out of an emerging tradition of ideas and practices that have profoundly impacted me as a person. That tradition is represented here in three essays which reflect different facets of postmodern psychology.

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I am sure my affinity for these ideas and practices began long before I had the language to describe them. However, it was with the reading of White and Epston's (1990) *Narrative Means to Therapeutic Ends* that I began to find the words to make real a sweeping family of ideas about--for want of any single unifying phrase--the politics of experience. Most of where I have traveled since being introduced to White and Epston's ground-breaking ideas was articulated or presaged in this brilliant book.

Drawing liberally from a wide variety of quarters, White and Epston argued that we construct our experience through discourse--through the way we collectively symbolize and communicate about it. The product of this ongoing conversation is *stories,* not truths, and our theories and practices of psychotherapy are among those stories. What makes this process political is that it is governed by power dynamics--an idea most fully explored by Michel Foucault, whose writings Michael White draws on extensively.

One way to summarize this notion is that experience is socially constructed according to a decidedly non-democratic process. The power to promulgate and enforce one's stories is the power to play a dominant role in the collective shaping of lived experience. Of course this vision was expressed by feminist writers long before *Narrative Means to Therapeutic Ends,* and indeed White and Epston are quick to acknowledge their identification with feminist ideals. What made their book particularly compelling for me is that it described how dominant stories contribute to the marginalization of both men and women, and it pointed out that psychotherapy itself can be seen as

yet another story with the power to liberate or oppress in equal measures.

White and Epston advocate for collapsing the hierarchies which characterize the relationship between the helper and the helped, so that relationship does not duplicate the disempowering dynamics they describe at a grander social scale. Like many adherents of contemporary, competence-based approaches to psychotherapy, they propose that it makes sense to bring forward the wisdom of persons, rather than to identify and treat their purported pathologies. Although this perspective is becoming increasingly widespread, it reflects a dramatic reversal of many traditional conceptions about the task of therapy.

These thoughts and many more reflect the wave of ideas and practices the intellectual community identifies with the term *postmodernism.* It is difficult to say where the wave started; all waves are undulations in an ever-shifting body of water. Certainly many German philosophers including Dilthey, Heidegger, and Husserl are identified with the prominence of postmodern thought in contemporary academic circles (if not in the conduct of public policy making). Hovering behind my own work over the past several years--mostly through secondary sources--have been Michel Foucault (1980), Jacques Derrida, and Richard Rorty (1982). Each have been prolific contributors to a postmodern discourse which is changing the way we view ourselves and the world, and re-shaping our practices of living.

But what *is* postmodernism? We owe it to Thomas Kuhn (1970) for coming up with the compellingly simple notion of the *paradigm shift,* a concept which helps to explicate the segue from modern to postmodern. Guba and Lincoln (1994) describe "paradigm" this way:

> ...a set of basic beliefs (or metaphysics) that deals with ultimates or first principles. It represents a worldview that defines, for its holder, the nature of the 'world', the individual's place in it, and the range of possible relationships to that world and its parts, as, for example, cosmologies and theologies do. (p.107)

Kuhn described how, from time to time, the paradigm which underlies our accumulated body of scientific knowledge becomes more unstable as we constantly attempt to accommodate/exclude new information, ideas, and experience. At some point, the basement begins to collapse, the house begins to fall, and we are forced to shore it up on a different sort of foundation. The essays collected here rest on that new foundation.

The relative youth of the ideas they draw upon is reflected in my frequent reference to postmodernism's critique of modernism; postmodernism still largely identifies itself in opposition to the paradigm from which it is emerging. But I have chosen my metaphors carefully: I think it is less apt to describe postmodernism as a new abode to house our knowledge than it is to depict it as an alternative foundation material introduced to keep the walls up on a faltering dwelling.

We are born into a world massively dominated by the modernist zeitgeist, so that a postmodern psychotherapy still rests on a foundation betraying many traces of modernist thinking. As much as these essays may appear to adopt an either/or stance for the purposes of demarcating a distinction, I acknowledge that it can be difficult to draw a sharp line between the two traditions.

That line is drawn with increasing regularity, though, as commentators attempt to capture the implications for theory and practice of Kuhn's paradigm shift. At the abstract end of the continuum, Donald Polkinghorne (1988, 1993) clearly identifies postmodernism as the critique of an entrenched epistemology closely identified with formal logic and the methodology of the natural sciences. In a more concrete realm, postmodernism manifests itself in a range of innovative psychotherapeutic practices, including reflecting teams, externalization of the problem, cultural and gender-caucuses, and many more.

I believe postmodernism is most simply characterized as the shift from: 1. A natural science worldview with an enduring faith in an objective truth that we get closer to as we refine our methods of measurement and description; to 2. A hermeneutic worldview which equates truth with interpretation and tips a hat to the context which

gives rise to the interpretations we make. Like the lead domino in a row of thousands, this shift sets off a chain of dramatically different ideas and practices. The three essays to follow articulate some of those, guided by the writings of the many eloquent theorists and practitioners who have influenced the work between these covers.

From sociologists Berger and Luckmann (1967) I obtained a detailed account of how, over many generations, we collectively fashion our interpretations of the world and its workings, both natural and human. These interpretations have longevity and substance; they constitute what Berger and Luckman call the "paramount reality" of experience, because they reside in language--that "objective repository of vast accumulations of meaning and experience, which it can then preserve in time and transmit to following generations" (p. 37).

This is the social constructionist orientation explored in depth by Kenneth Gergen (1985, 1991), who has become a premiere commentator on the place of postmodern thought in contemporary psychology. With family therapist Lynn Hoffman (1985; 1990), Gergen has forwarded my understanding of the evolution from a *constructivist* to a *social constructionist* epistemology (Paré, 1995). Constructivism emphasizes how we interpret the world (including our clients) through our own subjectivity; social constructionism points to the manner in which we collectively make meaning of our experience through discourse.

George Howard (1991) sheds light on both of these processes. He helped me to see how the premises we hold determine what we experience, what we take to be truth. In his bold account of science as narrative he argued, in effect, that there is no reason to exclude the revered body of scientific knowledge in the postmodern reconsideration of epistemology. Stories, argues Howard, reflect their contextual or cultural origins, and this goes for scientific stories just as it does for the folk tales of the Bornean bushperson.

The notion of culture (rather than "reality") as the originating point of knowledge has come to be a central organizing metaphor in my own work (cf. Paré, 1995, 1996). In this I have been influenced by the eloquent writings of anthropologist Clifford Geertz (1973;

1976; 1983), and by the clarity with which cognitive-cum-cultural psychologist Jerome Bruner (1986; 1987; 1990) reminds us that "human beings don't terminate at their own skins; they are expressions of a culture" (1990, p. 12).

New Zealand family therapists Kiwi Tamasese and Charles Waldegrave live and work in a milieu where the different realities of ethnic and gender cultures are palpable on a day-to-day basis. They have moved me as much by their impassioned presence as by their sweeping critique of the colonizing traditions of what they call "Western-centric" psychology. From Tamasese and Waldegrave (1991, 1994) I have come to appreciate that the postmodernism critique is far more than an intriguing parlour game for cerebral academics; instead it touches on fundamental issues of justice, compassion, and human freedom.

At stake is the dignity of persons. The thinkers and practitioners who have informed these essays are bent on re-authoring the story of psychology. They are siding with the mother who is construed as the cause for her child's schizophrenia, who is blamed for her husband's sexual abuse of her daughters. They are intent on revising our practices of psychological assessment which typecast persons and freezes their identities with professional pronouncements about their innate deficits. They are determined to celebrate uniqueness, to promote gender and cultural equity, and to separate persons from problems.

Which brings me back to White and Epston. All of these themes and many more are echoed in their writings and practice. At times over the past years when I have fretted over my labours and wondered at my career prospects in an era decidedly unkind to psychotherapy, I have always derived solace in knowing that, if nothing else, my life has been greatly enriched by exposure to their work.

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The ideas which inform this work beckon me forward--compelling, alluring, but difficult to grasp and hold onto. We are

born into a world constructed quite differently than the one portrayed in these essays. We are told we are "bad" when we deviate from some standard imposed from above, and thus begins the story of our essentially flawed nature. Our fresh and original perspectives of the world around us (particularly fresh and original when we are very young) are corrected by authoritative figures who appear to hold a monopoly on truth, a firm grasp on a reality that--we come to believe-- eludes us in our youthful ignorance. Right and wrong, true and false, real and unreal: day by day, the world and everything in it are reified--fixed liked photographs in developing fluid.

This reification is the expression of a mode of thought that Bruner (1986) says has dominated the Western mindset since Plato. It is a mindset in opposition to the values expressed throughout these pages. Part of the exhilaration of compiling these essays comes from the sometimes self-important sense of ideological purity that the act of writing affords. It is easy to feel congruent with one's ideals, close to that beckoning light, when your only companion is a keyboard. In the practice of daily living, however, I continue to be dogged by a persistent set of unfavored beliefs and practices which sneak into my repertoire despite my best efforts to replace them. As a result, I frequently stumble into the yawning gap between my intentions and what White (1995) would call the "real effects" of my actions.

In the practice of daily living, it is easier to assume we have an answer than to construe our view as one of many. Ironically, this is even true when the very view we are trying to espouse champions multiplicity. In my enthusiasm for the work contained here I am often dismayed to find myself perched on the high horse of righteousness and truth, adhering to "narrative correctness" with the tenacity of a television evangelist. In my conversations with clients, I frequently catch myself directing their stories through my value filter, and passing judgment on them. And even in those special moments when I feel I have "got it right', when I have joined with a client in an enlightened understanding of how entrenched stories lead us all to assume rigid roles in life, I sometimes drive home to

my family oblivious to the responsibilities I have overlooked in playing out the time-worn story of male breadwinner, workplace warrior, household sloth. It is difficult to carry others' realities while we nurture our own.

It is also difficult to truly collaborate. This became particularly evident to me through the experience of facilitating a support group for working therapists during the period this dissertation was being written. I had conceived of the group along narrative lines, and hoped to conduct it with a focus on some of the ideas I have written about in the essays to follow.

Thus began my entry into the challenge articulated at great length in my third paper on the place of knowledge in therapy. How can we bring forward our knowledges and ideas in a manner which does not exclude or dismiss those of others? This dilemma was very real for me as I experienced myself on one hand stubbornly adhering to my own ideas in the face of group preference for an alternate structure, and on the other hand, deferring to other members to the extent that we drifted, rudderless and without leadership.

I found our group process did not flow until I let go of the structures I had hoped to bring to the gathering. In so doing, I also let go of many expectations about what we would be doing together, my vision of what a "narrative group" would look like. I think we are just beginning to develop a sense of how these paradigm-shattering ideas can be put into practice in ways not merely ideologically exemplary, but effective as well.

Despite these trials, though, I am forever grateful for the opportunity I have had to engage in the task. At a time when the political pendulum has taken what I view as a disturbing swing to the right, the postmodern wave washing on the shores of psychotherapy fills me with a sense of hope. For the past several years, I have waded in those auspicious waters. The effort to make sense of the ideas and to introduce them into my practice has been my apprenticeship as a psychotherapist. The work has just begun, but I have learned much about my work, my world, and myself. It has been an immeasurably rich experience.

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The three essays here examine some specific implications of adopting cultural and narrative metaphors in the practice of therapy. They follow on three others of more sweeping scope which constituted my Masters thesis. The first of those, *Of Families and Other Cultures: The Shifting Paradigm of Family Therapy* explored the evolution of family therapy theory from a systems-oriented view influenced by the science of cybernetics, to a cultural view, which draws on a variety of human science traditions including hermeneutics, literary theory, anthropology, and narrative.

The second paper, *A Cultural Perspective on Families and Family Therapy,* drew on clinical examples to illustrate how a view of families as cultures (rather than systems) shifts the focus of family therapy from normative prescriptions for family "functionality" to issues of intercultural harmony. I argued that the addition of a body of cultural metaphors helps to address a number of critical contemporary concerns not adequately encompassed by traditional systemic formulations--including issues of meaning and language, narrative, politics and practices of power.

In the third of my Masters papers, *The New Social Constructionist Approaches to Family Therapy,* I described how postmodern thinking is currently manifest in the contemporary practice of family therapy. The essay proposed that family therapy's focus on systemic interaction is being replaced with a privileging of the meaning-making and interpretive dimensions of experience. The resulting clinical applications place a higher emphasis on clients' abilities to construct solutions on the strength of their own resources, and on the constitutive power of language and conversation.

This new collection of three essays takes the same metaphorical ball and runs with it. For the most part, these essays shed light on further implications of postmodern thought on psychotherapy. By the third paper, there is the glimmer of a glance back at modernism, and the attempt to recover some pieces jettisoned in the evangelical fervor of these exciting new treatment modalities. The *Afterword* adds more to this discussion of what

might be called a break from postmodern or narrative orthodoxy. It also points to further directions for research and practice.

The first paper here, *Us and Them: Therapist Talk and other Dividing Practices,* is essentially an anecdotal account of my personal deconstruction of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The paper began to congeal at a time when my theoretical understandings were bumping into professional language on a practicum placement. I began to notice the discrepancy between the lay language I applied to my experience on the one hand, and clinical terminology and diagnostic classification on the other. And so I determined to take a closer look at DSM etymology.

The DSM is increasingly utilized to categorize persons who come for therapy according to the pathologies they purportedly have. As such, it typifies a natural science-based, expert-oriented tradition which contrasts sharply with the ideas and practices for which I advocate throughout this dissertation.

The launching point for my examination of the DSM is the encounter with a "depressed" client. Robert's example leads me to view the DSM as a taxonomy founded primarily on deviance from a statistical norm. In the terms of the discussion above, this is classic Foucault--the illustration of a person oppressed by a dominant story (the DSM) originating from a highly specialized institutional context (Psychiatry).

The themes explored in the first paper are woven throughout the next two essays as well. The second essay evolved over an extended period of time, during which I worked with a number of persons who have engaged in varying degrees of abuse with their partners and family members. This work poses the difficult task of balancing a favorable view of the client while acknowledging the extent of the hurt they have inflicted. For me, the narrative metaphor--particularly as it is exemplified in the work of Alan Jenkins--has been most helpful in accomodating these two important pieces.

In *Intentions gone Awry: Bringing Forward Values in a Narrative Frame* , I present a narrative perspective of persons who engage in abusive behavior. The DSM has a wide selection of

potential pathology-based labels to account for such persons and their actions, including "Conduct Disorder" and "Antisocial Personality Disorder". Instead, I depict a view which separates the person from the problem, so that we may simultaneously take a clear moral stance against abuse while helping to bring forward a person's compassionate intentions.

This second essay describes how most established psychotherapeutic traditions have great difficulty contemplating issues of intention, choice, and agency because they are founded on natural science-informed metaphors. For the most part, natural science is intent on discovering the objective workings of a causally-determined universe. Within such a paradigm, it is easy to accommodate a view of abusive behavior as the symptom of an underlying pathology (in the tradition of medical science); it makes far less sense to focus on a man who abuses as someone constrained in his efforts to make responsible and respectful choices in his relationships.

This essay explores the ways in which a narrative metaphor offers an alternative frame for viewing and working with persons who are attempting to shed their abusive ways. It concludes with a discussion of the moral dimension of therapy--a dimension inevitably laid bare when by metaphors which construe persosn as agents of their own choices.

The third essay, *Cultural Wisdom: Reflections on Knowledge and Accountability in Postmodern Clinical Practice,* continues the task of contrasting the ways in which the modern and postmodern paradigms manifest themselves in the consulting room. This paper grew out of a wide range of therapeutic moments in which I found myself straddling paradigms, as it were--striving to maintain a "curious" stance while simultaneously nurturing some strongly held ideas, beliefs, and feelings. At various times, I have found my work to lean further than I believe is helpful in one or the other of these directions: sometimes my devotion to "not knowing" seems to compromise some contribution I might make to the conversation at hand. At other times, I find I get ahead of my client(s), leading the way to a place they may not be ready or inclined to visit. This paper

attempts to locate an appropriate balancing point between these extremes.

Here the lens widens again to something approaching the scope of the earlier three essays mentioned previously. I return to that "heart-of-the-matter" (Hoffman, 1985) issue of epistemology to examine the question of knowledge in the therapeutic encounter. If the essay is successful, it helps to delineate the different assumptions about knowledge underlying modern and postmodern paradigms.

What makes this essay different from the previous five mentioned here is that it strives to recover some pieces of the work overlooked, dropped, or rejected outright by avid postmodern practitioners. In my mind, it represents the beginning of a worthy project--the task of translating those apparently beneficial aspects of modernist practice into a language more suited to a postmodern epistemology. I will have more to say about this in the *Afterword.*

The *Cultural Wisdom* essay makes the bold charge that a traditional scientific orientation to psychotherapy is not very different from racism. My argument hinges on the distinction between law-based and culture-based knowledges. Law-based knowledge--the Holy Grail of science--imparts a view of persons as specific instances of general principles. When science is regarded as a cultural story, as discussed earlier in this foreword, a law-based perspective entails the imposition of one culture's (ie. the scientific culture of psychotherapy) meanings on another's (ie. the family or individual). It seems fair to say that this is what we usually mean by the term "racism".

And so the third essay is a cautionary tale of sorts. Clearly located in a narrative perspective, it says we should avoid the colonial tradition of making too much of our own knowledge at the expense of the others'. But I also argue that we might *reconstrue* our clinical knowledge, and see our expertise as a familiarity with various cultural stories rather than universal laws. This epistemological re-tooling makes it possible for us to maintain a postmodern view of therapy while acknowledging our own part in a therapeutic conversation. That part is unavoidable, and yet largely

overlooked in a body of social-constructionist literature devoted to "not-knowing" and "client expertise".

It seems to me that we are only just beginning to plumb the waters of postmodern psychotherapy. The daring and compassionate thinking which inspires the essays here has unveiled some grievous inequities in our established "therapeutic" practices. Certainly a wide range of innovative theorists and practitioners have begun to construct promising alternatives; but the exhilarating conversation that is postmodernism also reminds us of the daunting task of achieving a fair balance, and mutual exchange, a shared meaning. It is, and forever will be, a work in progress.

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CHAPTER TWO:

Us and Them:
Therapist Talk and Other Dividing Practices

Robert, 21, came to therapy after dropping out of community college due to a series of low grades, failures, and incompletes. He'd just undergone a psychoeducational assessment which uncovered no evidence of a learning disability, and which indicated above-average intelligence.

He said he's really only interested in music, that he's always had difficulty applying himself to school work. His days are spent mostly at home, where he lives with his parents and two brothers, watching television, playing video games, and composing music on his electronic keyboard.

I offered Robert the chance to get the input of a team of my colleagues. He readily agreed. We sat and talked while two chartered psychologists and a doctoral student observed from behind a one-way mirror. Robert described his difficulty "approaching people" and portrayed himself as suffering from low self esteem. As he spoke, he peppered his talk with self-defeating phrases and pessimistic projections of his prospects in life.

"A clear case of depression", concluded my colleague Grant, once the team had shared its reflections and Robert had left. Grant is director of the practice and a highly competent therapist with many years experience. His comment deserved attention, and yet it prompted me to second-guess my own impressions. Robert had no air of heaviness or sadness about him. On the contrary, despite his self-defeating proclamations, I experienced Robert as relaxed and affable. As he talked about his musical ambition and his struggles converting his vision to a finished work, I formed the picture of an inspired but frustrated artist. I felt energized in his presence.

"And yet not depressing", I countered. Grant readily agreed, describing my client as having a "delightful" personality. We were trying to share our experience of Robert, and words were getting in the way.

My discussion with Grant about my client Robert tweaked a curiousity which had been growing in me for some time--a curiousity about the words we use to describe our own mental and emotional states. Many times I have heard clients (as well as friends, family, and myself, for that matter) speculating on their own mental or emotional status, weighing out the appropriateness of some particular word to portray their experience.

My doctor said I'm depressed. Maybe I <u>am</u> depressed . I think I'm having anxiety attacks, but I'm not sure. We figure we're probably a dysfunctional family; what do you think?.

I have become increasingly fascinated by this speculation. Why is it that we might stand by our claim that our arm hurts, or that we feel sleepy, in face of contradiction by the most imposing of experts, but we will agonize over whether we are truly *depressed* or not? If we are not the authorities on our moods, who is? And how is it that we might disagree about the correct description of a person's mood, while apparently sharing an image of their disposition? How is it that from Grant's perspective, Robert appears *depressed,* and from mine, he does not?

"Words are like freight engines that are pulling boxcars behind them filled with all of their previous meanings," says de Shazer (1991, p.67). My exchange with Grant prompted me to look closer at the various possible boxcars hauled by words like *depression* and *anxiety* to find out where they originate, to come to an understanding of the power they hold over us--not just as clients, but as persons.

This essay is an exploration into words and their meanings, and the cultural practices which are both *reflected in* , and *instigated by* the language we use. Words provide an entry point for the discussion which follows, but it would be inaccurate to portray them as the *beginning* or the *end* of this inquiry. Circles have neither beginnings nor endings.

A Circle of Inquiry

From the original text of a conversational exchange with a colleague over Robert's *depression,* I have found myself spun through a wheel of meanings encompassing fundamental questions about our shared experience of language. The wheel has often turned: spinning through the nuance of word meanings, to a view of mental health as a collectively constructed and arbitrated according to cultural specifications, and ultimately to the specifications for gender and personhood into which we are born. Ultimately, this account is concerned not so much with Robert's individual story per se, but on Robert as representative of each of us caught, like bugs in a jar, within the container of language.

Am I depressed? Am I anxious? Am I dysfuntional? As this inquiry has unfolded, I have come to see these questions--which most of us ask ourselves at some time or other--as far more than a mere musing over word meanings. They are statements of an ongoing battle over our own experience. Here, the circle is at its widest. But let us return to the beginning, which is not a beginning, but a point of departure.

Deconstructing Therapist Talk

After my conversation with Grant, I concluded we were speaking different languages as we talked about Robert's mood. Grant was speaking "therapist talk", relying on professional idioms, while I was speaking colloquially, describing Robert using the language of everyday speech.

In each case, the "freight engine" *depression* was hauling a different array of cargo. The boxcars behind my *depression* were typical of those associated with the word in vernacular use, which is (more or less) represented in dictionaries of the English language. Grant's usage of the word was professional. He was speaking "therapist talk", and his meanings could be traced to psychology textbooks, clinical conferences, and perhaps most of all to the Diagnostic and Statistical Manual of Mental Disorders IV (DSM) (American Psychiatric Association, 1994).

The DSM was first published in 1952 to stabilize psychiatric nomenclature. Since that time, it has become a widely influential text within the therapy community. Translated into several languages, and revised to correspond to medicine's international system of disease classification, the terminology of the DSM is increasingly applied to recipients of therapy and counselling services by psychiatrists and psychologists alike.

For some time, I have been curious about this language, which utilizes many words common to everyday speech in a specialized way. When Grant relied on the DSM's clinical dialect to describe a young man striving for changes in his life, my curiousity deepened.

I decided to embark on a deconstruction of DSM's *depression* in the hope of furthering my understanding of the linguistic chasm

which had opened between my colleague and I. The "deconstruction" I speak of reflects Goolishian's (Anderson & Goolishian, 1989) use of the word: "to deconstruct means to take apart the interpretive assumptions of the system of meaning that you are examining, to challenge the interpretive system in such a manner that you reveal the assumptions on which the model is based" (p. 11). In Carson's (1986) terms, this is an examination of "the way we speak about the topic under discussion" (p.17) so that the words therein "may then have a way of surprising both the researcher and the participant with unexpected insights" (p. 17).

Another way to capture Goolishian's sense of an "interpretive system" is to speak of cultural origins (Paré, 1995, 1996). I think it is useful to think of systems of meaning as languages imbedded in cultural contexts. In this case, the DSM is a language founded on shared assumptions not common to everyday speech, a language located within the culture of therapy. That culture is peopled by psychologists and psychiatrists in hospitals, agencies, and private practices.

Webster's (1975) defines "depressed" as "1. pressed down. 2. lowered in position, intensity, amount, or degree. 3. flattened or hollowed, as if pressed down. 4. gloomy, dejected, sad" (p. 489). As a description of mood, definition #4 probably captures the overall feel of the word "depressed" as we use it in daily speech away from a clinical context[1]. I could add more contemporary terms like "down" or "bummed out" to flesh out the description. According to the meanings evoked by these words, I did not experience Robert as depressed, and neither did my colleague Grant.

In DSM, *depression* is part of the definition for *major depression* . A *major depressive episode* must be present for a diagnosis of *major depression*. A *depressed mood* may be a feature of a *major depressive episode* , but the DSM allows for such an incident which is characterized instead by a sustained loss of interest or pleasure. While Robert's air was not particularly heavy, his experience was certainly marked by lack of interest bordering at times on all-out inertia. Speaking from the culture of clinical psychiatry, Grant was quite "right": when Robert's lack of interest

was combined with a number of other criteria stipulated by the DSM, his current state fit the definition of *major depression.*

This is therapist talk. The lay population is not fluent in therapist talk--the web of meanings which differentiate psychiatric diagnoses. Although it overlaps with the language of everyday speech, therapist talk is clearly a distinct language. That is why it is possible for laypersons to speak about Robert's *depression* without ever having heard of a *major depressive episode* . This raises an important question about who is the specialist on the client's mood, or mental disposition for that matter. Borrowing once more from de Shazer's metaphor, if the word meanings of the therapy community dominate the discussion of the client's complaint, who is driving the train?

Descriptive Definitions

The crystallization for me of this notion of parallel languages drew me deeper into an examination of DSM's rigorous taxonomy of mental disorders. What assumptions underly DSM's meanings, and what implications do those assumptions have for those to whom its labels are applied?

Language is inescapably rooted in a bed of assumptions which themselves reflect a cultural tradition (Rorty, 1982). Whether we describe our clients to colleagues or document our sessions in case notes, whether we reflect on process or set therapeutic goals, we are guided by innumerable assumptions which shape the work we do and have profound implications for our clients.

We cannot escape these assumptions, because we cannot escape language. As much as we may try to get at our clients' experience in its pureness and essence, we become entangled in the words they use to voice that experience, and the words we choose to describe it. More than mere signs for an indisputable external reality shared by each of us, the language we use determines the meanings we attach to things, thereby shaping our experience of them (Berger & Luckman, 1967; Gergen, 1985, 1991).

While the DSM is by no means favored by all clinicians, it comes out of a classificatory impulse, and represents a "comparative"

process of engagement (Smith, 1991) with a text. In this case, the "text" is a person's behavior. Rather than viewing behavior as "expressions of a creative spirit which any interpreter must somehow engage if interpretations are to be made that are faithful to an author's original intention" (Ibid, p. 190), the comparative process relies on typologies. Borrowing again from de Shazer's metaphor, DSM adopts typologies to prescribe as precisely as possible which boxcars should be attached to the freight engines which are the labels for mental disorders. Some of the labels, like "anxiety", are words commonly used in everyday speech, but their specifications are distinct.

For example, as a layperson, I might use the word "anxiety" to mean the state my Uncle Norman was in while his pet schnauzer was suffering a bout of the worms. The boxcars of that particular engine called "anxiety" (with me in the conductor's seat) might include much dusting behavior, the tendency to remain glued to television talk shows, and an overindulgence in wine coolers.

DSM's "anxiety" pulls a wide variety of alternate boxcars, including shortness of breath, dizziness, and palpitations. However, despite the differences in meanings attributed to its terminology, DSM's definitions are of essentially the same ilk as the one I use for characterizing Uncle Norman's state. I don't look down Norman's throat, or scan his EEG reading to decide that he is anxious, and neither does the DSM. Disorders are not classified according to the presence of physically measurable components such as hormone or neurotransmitter surpluses/deficits. DSM takes a *descriptive* approach to the classification of mental disorders.

The symptoms which constitute the description of a mental disorder are typically behavior patterns exhibited to some degree at some time by most persons. What qualifies them for the label "disorder" are the combinations in which they are found, and the frequency of their occurence. Consider *depression.* Behavior patterns associated with *Major Depression* include: depressed mood; loss of interest or pleasure; poor appetite or overeating; insomnia or hypersomnia ; low energy or fatigue; low self-esteem; poor

concentration or difficulty making decisions.; feelings of hopelessness.

I have exhibited each of these, or combinations of these, patterns at some time in my life. I expect the same is probably true for most readers. However, I am not sure I have every qualified as *clinically depressed,* whereas Robert may--because of the frequency or duration of his constellation of behaviors, or due to their specific pattern of co-existence (ie. *co-morbidity).*

The introduction to the DSM reminds readers that a classification of mental disorders does <u>not</u> classify people, but rather "what are being classified are disorders that people *have.*" [emphasis added] (p. xxii). And so while I do not "have" a mental disorder called major depression, it may well be that, according the language of the DSM, Robert does "have" one of these disorders.

It is probably worth emphasizing that a statement that Robert *has* major depression is of the same logical set as the statement "Caitlin *has* spring fever" made of a child who paces the living room restlessly as the snow melts in April. In Wittgenstein's (1963) terms, the DSM engages in a particular *language game* involving the classification of persons into the "haves" and the "have nots". This classification is done on the basis not of an *inherent* difference between them, but according to an arbitrary set of rules delineating key constellations of behaviors.

Webster's (1975) first definition for *symptom* follows medicine's usage of "any condition accompanying or resulting from a disease" (p. 1849). In turn, *disease* is equated with *illness.* But as Szasz (1967) pointed out in his seminal work almost three decades ago, the expression 'mental illness' (like 'mental disorder') is a *metaphorical* term which has "attained a high degree of concretization and [begun] to lead a life of its own" (p. 295). It does not designate an endogenous or organic anomaly in the same way that the term "physical illness" does.

Mental Disorder as Divergence from the Mean

The DSM can be seen as a narrative originating from a specific cultural subgroup which constructs persons according to its own

particular rules. These rules are the scaffold of the DSM's narrative. As I disassembled this scaffold in my own searching, I discovered a narrative founded upon the principle of divergence from the mean as the defining characteristic of mental disorders.

Consider Robert. He complained of *low self-esteem,* and his self-descriptions were consistent with the typical use of that phrase in both professional and everyday language. But most of us have displayed some measure of low self-esteem at some time in our lives. If self-esteem were operationalized in terms of self-complimentary statements per day, humankind would be clustered in a bell-shaped distribution around a mean number of daily self-complimentary statements.

This is the so-called *normal curve.* Subjects who fall under the curve to the left (more than likely Robert, eg.) make fewer self-complimentary statements per day than the mean; subjects to the right make more than the mean. But how far below the mean (ie. "away from the norm") must one be to qualify as having *low* self-esteem? How low is "low"? And on the other side, how many self-complimentary statements must a person make per day to be considered abnormal--or in DSM terminology, suffering a *narcissistic personality disorder?* The decision is arbitrary.

Like the DSM's other criteria for depression (depressed mood; poor appetite or overeating; etc.), self esteem can only be gauged in *relative* terms. It can only be understood and defined relative to the mean. The same is true of all mental disorders as classified by the DSM: to "have" a mental disorder, one must be sufficiently different than the average person.

A Normative Model of Mental Health

This normative view of mental health has infiltrated everyday life, although Foucault's (1965) explorations show that the separation of the sane from the insane is a relatively recent phenomenon in human history, and Szasz (1967) details how the term *mental illness* was added to the lexicon around the turn of the century. The DSM itself began as a classification of mental syndromes, which it called

"reactions"; the word was changed to "illnesses" in 1968 to bring the manual closer in line with medicine (Tomm, 1990).

These "illnesses" are the stuff of *abnormal psychology* . The word *abnormal* is a relative term situating its subjects at some distance from the population mean, and in this sense might be assumed to be synonymous with words like "original" or "unique" for the alternate vision it suggests. But deviation from the norm has come to take on extra, and unambiguously pejorative, meanings. The dictionary lists the word *abnormal* as synomymous with *unnatural.* The word *aberrant* is defined as "wandering; straying from what is true, correct, normal, or typical" (Webster, 1975, p. 3). This web of meanings carries a message: to behave like the majority is to manifest our true or correct nature; to diverge from the norm is to display the symptoms of mental illness.

Foucault describes how, with the entry of psychiatry, medicine, and other social sciences into legal deliberations during the past century, society has increasingly appealed to what he calls "normative rationality" (Rabinow, 1984, p. 20). Statistical measures and judgements of populations come to dominate, contributing to "the systematic creation, classification, and control of "anomalies" in the social body" (Ibid, p. 21). In this widening context, DSM, as a dominant language of the culture of therapy, can be seen as co-opted by a view which identifies *anomalous* with unhealthy and *undesirable,* and equates adherence to the norm with naturalness and moral rectitude.

This raises serious concerns about the role of the therapist guided by a classificatory system which is, in effect, a language dedicated to the delineation of haves and have-nots, of *us and them.* . The accordance of the status of "having a mental disorder" rings of what Foucault calls society's "dividing practices" (Rabinow, 1984):

> In this process of social objectification and categorization, human beings are given both a social and a personal identity. Essentially 'dividing practices' are modes of manipulation that combine the mediation of a science (or pseudo-science) and the practice of exclusion--usually in a spatial sense, but always in a social one. (p. 8)

The irony of this classificatory response to so-called mental illness is that it can be seen as itself contributing to personal distress, to alineation not just from each other, but from oneself. "Humanity is estranged from its authentic possibilities", wrote Laing (1967, p.11), describing individuals trapped within a society which gives primacy to conformity over self-expression. For Foucault, this estrangement is intimately tied up with practices of power. Drawing on Foucault, White and Epston (1990) write:

> This modern system of power is one that not only renders persons and their bodies as objects, but also recruits persons into an active role in their own subjugation, into actively participating in operations that shape their lives according to the norms or specifications of the organization. (p. 71).

Gendered Subjugation

My own most acute experience of living with the subjugation White describes was probably my high school years, when the distinction between genders suddenly acquired a fierce intensity, fueled by hormones and fed by an oppressive dogma of duality. We were either female or male; and those features of our personhood which distinguished us were vested with an importance which overshadowed every other aspect of our beings.

As a male, my mandate was clear: conform to that subculture's specifications for maleness, or risk abandonment and shame on the periphery, the object of target practice by thick-skinned schoolmates with razor tongues. "Maleness" was next to godliness--the exalted essence of a schoolboy's being. That essence was equated with physical strength and athletic prowess, a disdain for book learning, the ability to dish out and withstand belittlement. Homophobia was rampant. Traces of the feminine--a sensistivity to others, an expression of vulnerability--were to be purged from one' s character and decried in cohorts. As boys, our task was to locate ourselves firmly and unambiguously on one side of a line which marked the central duality of the culture of adolescence, the delineation of male from female.

I came to this era underweight and underheight, with no hint of facial hair--a pre-pubescent boy with a history of high academic achievement entering into the lion's den of junior high. Fortunately for me, I'd always enjoyed sports; I was able to parlay my modest athleticism and some social skills into an alliance with a group of friends who more fully embodied the archetypes of maleness. I joined "The Boys", as we called ourselves with inspired transparency, and I negotiated my way through shark-infested waters to emerge scarred and bruised, but with limbs largely intact.

When I look back on these years, it is usually in a spirit of amusement mixed with a lingering sense of indignation and bitterness. This is the crucible that forges us; but, like Bronwyn Davies (1989), I believe the crucible "is something individuals can attempt to change through a refusal of certain discursive practices or elements of those practices" (p. 13). I aspire to new ways of being which are divested of such harshly enforced specifications--specifications for gender, but ultimately for our own personhood.

Davies (1989) brilliantly depicts this process as it applies to the specification of child versus adult, male versus female. She describes how sex and gender can be seen both as "elements of the social structure, and something created by individuals and within individuals as they learn the discursive practices through which that social structure is created and maintained" (p. 12).

Drawing on her observations of preschool children, Davies essentially portrays the consequences of the social construction of gender. Her descriptions are strikingly resonant of the self-subjugation which Foucault speaks of, and which earns central attention in White's (1992) narrative approach to therapy. Describing the constrained throwing motion of a young girl, Davies refers to"the 'inhibited intentionality' that comes with learning to see oneself primarily as the object of anothers' gaze" (p. 18). In a different context, Foucault (White & Epston, 1990)) also refers to "the gaze" as it applies to both men and women--the oppressive monitoring by society (and self monitoring by each of us) that follows from the pressures to adhere to cultural specifications for our behavior and our being.

Here, we have arrived at a panoramic view of society, and of the normative and prescriptive pressures embedded "in our own identities and in the language and the narrative structures through which we come to know ourselves" (Davies, 1989, p.71). Here, the circle completes itself: it revolves through a psychiatric text which divides the mentally disordered from the mentally normal, acting on the same sort of polarizing tendency that crystallizes boys and girls in their rigidly prescribed roles. Turning further still, we arrive at a single word: *depression* . In my mind, the disparity in meanings between my version and Grant's version of that word betrays the policing of personhood which is a central constraint to Robert's self-realization, and to the self-realization of all of us.

Robert says he never made any friends to speak of at school. He'd never learned the social protocol, never adopted the prescribed ways of being. When he began taking university transfer courses at community college, the pattern continued.

Encouraged by his parents, he'd enrolled in a commerce program, although he betrayed no interest in business or related topics. By Robert's description, his father (lawyer), and his mother (teacher) are brisk and practical-minded professionals who chose careers for pragmatic reasons. In contrast, Robert has a divergent, day-dreamy quality to his personality--a moody expressiveness which transforms into art at the keyboard.

In the cultural milieus of the school, and of his own family, Robert defies some key specifications for being. He's a black sheep, toiling on the fringes of these micro-societies.

His toils are his compositions. I asked Robert to record some of them for me, and carried the tape with anticipation--the first non-family member ever to be privileged with one of his recordings. After a few days, I inserted the cassette into my tape deck. Images of wet leaves and rainy fall days, a hint of sadness, a glimmer of possibilities: the evocative stylings of an artful musician.

Beyond the Tribal Fire

It takes courage to assert our different-ness, to put forth that which makes us unique. Writes Mair (1988): "the speaker of a new word, a different story, has to leave the warmth of the tribal fires to live as an outsider, beyond the pale, isolated, often invalidated." (p.

135). And yet that different story is the core of our creativity, the fruit of a life-sustaining urge fuelled by our hopes and dreams.

Speaking of our tribal specifications for gender, Davies (1989) writes: "The task of evolving a thought form which goes beyond this particular dualism is almost unthinkable because of its embeddedness in our own identities and in the language and the narrative structures through which we come to know ourselves" (p. 71). It is *hard* to tell a new story, says Mair. "The story is a *place of battle.* In every story there is a fight for survival, there is a politics of assertion and rejection" (emphasis in original) (p. 132).

If, as therapists, we are intent on engaging with persons, rather than statistical averages, we need to attend to individual stories. "This is not a rejection of the 'facts'," writes Mair (1988), "but a recognition that human facts are constituted by the located context of the whole story. The story is the claim, it is not merely a container of facts" (p. 131).

And so for Robert and his *depression.* To the degree to which his mood is typified within the framework of professional language, Robert's story recedes into the background. His precious personhood, the seed germ of his self-expression and growth, is obscured beneath a latticework of technical specifications.

Rorty (1982) writes of how, for two millenia, we in the West have sought to categorize and differentiate the world, to fix its essences and to capture them for posterity, like butterfiles pinned to a canvas. He says it has been a misguided quest. In speaking of education, he says we need to see it "not as helping to get us in touch with something non-human called Truth or Reality, but rather in touch with our own potentialities" (p. 4).

Rorty's words resonate strongly for me. They speak of a tradition embodied in the DSM, but evident throughout the language, rituals, and institutions of our society. We are divided one from another by a classificatory impulse which polarizes us according to arbitrarily selected specifications. It is an impulse so bent on naming us that it loses us, or at least unnecessarily delimits us, in the process. I prefer Davies' (1989) fluid conception of persons as "complex, changing, contradictory creatures that we each experience

ourselves to be, despite our best efforts at producing a unified, coherent and relatively static self" (p. xi). As a therapist, I prefer to view Robert as a font of unimagined possibilities. As a person, I prefer to look upon life as a mystery always to be pondered, but never to be solved.

Footnotes

1. This assumes a fairly homogenous readership of North American English speakers. The English of "everyday speech" is also an interpretive system, and the general assumptions imbedded in everyday speech are not identical around the world.

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CHAPTER THREE:

Intentions gone awry:
Using a narrative metaphor with persons who abuse

"The subject matter of therapeutic conversation is, invariably, intentions gone awry".

(Parry & Doan, 1994, p.3)

I can't change you; you have to change yourself. That sentiment has probably been expressed--explicitly or implicitly--to therapeutic consumers since Freud's first patient slid onto a couch beside him more than a century ago. But curiously, the dominant therapeutic orientations which have arisen during those highly creative decades have paid only lip service to the assumption lurking behind it.

This essay is about the use of a model of therapy which actively promotes the assumption that persons can change themselves. As the discussion unfolds, I will propose that many dominant therapeutic orientations are hampered in their ability to do this--they struggle to address issues of personal agency, intention, value, choice, and responsibility because they rely on the causal, objective metaphors[1] of the natural sciences. I will explore the manner in which a narrative metaphor brings these vital themes forward, rendering it a particularly apt framework for working with persons who engage in emotional, physical, and sexual abuse[2].

Causality and Agency: A Poor Fit

Causality reigns supreme in the domain of the natural sciences. The scientific paradigm arose long before the contemplation of psychology as a discipline, and founded its methodology on the stuff of the physical world--the ore under a geologist's hammer, the fluid in a chemist's beaker, the living cells on a biologist's microscope slide. In this physical domain, objects are seen as acting on other objects according to the laws of nature--laws which *determine* or *compel* the unfolding of events.

To be sure, the natural sciences have had their share of paradigmatic upheavals this century (Hawking, 1988); however, it is fair to say that science continues to construe itself as a methodologically rigorous quest to determine what causes things to happen--an endeavour bent on uncovering the purported laws of

nature. As such, the scientific worldview continues to be immensely powerful in enacting change in the physical world. But it increasingly appears to fall short of capturing some central features of the *lived world* of human experience (Parry, 1991; Polkinghorne, 1988).

Bruner (1990) suggests our predominant psychological models fall short because they are still under the sway of causality, a cornerstone of the scientific paradigm. He says that because contemporary psychology has widely come to see persons as interpretive creatures (cf. Polkinghorne, 1988), we need to draw on metaphors which capture that meaning-making process: "to insist upon explanation in terms of 'causes' simply bars us from trying to understand how human beings interpret their worlds and how *we* interpret *their* acts of interpretation" [emphasis in original] (p. xiii). Elsewhere, he states "there are no causes to be grasped with certainty where the act of creating meaning is concerned, only acts, expressions, and contexts to be interpreted" (p. 118).

Bruner's (1990) premise is that psychology should draw on narrative--rather than scientific--metaphors. It should be concerned with *situated action* rather than *behavior* --"action situated in a cultural setting, and in the mutually interacting intentional states of the participants" (p. 19). These notions of context and intentionality set Bruner's description of situated action apart from a causal behavioral account. They exemplify an emerging narrative paradigm located in the *human*, rather than natural sciences. I will have much more to say about this as the discussion proceeds.

What all of this suggests is the notion of personal agency--a notion that fits poorly with science's law-based descriptions[3] because it rings suspiciously of persons making choices *in defiance of* any set of laws that purportedly constrain them.

The premise of this discussion is that, given that therapeutic intervention with perpetrators of emotional, physical, and sexual abuse is intent on helping them make responsible and respectful choices, it makes sense to draw on metaphors which accommodate that possibility. When we view abuse in objective terms as a "symptom" of a "pathology" which needs to be "treated", we draw on

metaphors which dovetail comfortably with the assumptions and practices of the natural sciences (including medicine). But missing from the foreground of this description is the person who *acts*, based on *choice*, founded on *intention*.

Psychology has been intent on associating itself with the scientific domain since the field's inception (Polkinghorne, 1988). Within that domain, events are understood to happen because they are impelled by other events. The language and metaphors of science enable us to understand human behaviors as the consequence of neurological programming, physiological development, drives, reinforcement contingencies, and so on. But it is scientifically blasphemous to depict a person as acting *in defiance of* these. It is one thing to depict the heroism of a mother re-entering a burning house to retrieve her child as the expression of maternal instinct aroused by hormones and abetted by adrenaline; it is quite another thing to see her as making a self-endangering choice *despite* a biological fear response as ancient as the species itself. This equally plausible description fits comfortably into a literary domain, and appears far more often than the former. But it is a description, a way of speaking, a manner of viewing human action, which falls outside the domain of science because it seems to imply a transcendence or defiance of so-called nature, and thus of science itself.

Howard (1991) would say science's problem with the second description is that it is about making choices, and choices simply do not fit in the natural science "story". He argues that, for all its intricate cross-referencing and appeals to objectivity, science is a *story* nevertheless. In its myriad allusions to "objective criteria", "reliability", "validity", and the like, science portrays itself as an endeavour that somehow transcends *stories* and locates itself in the *real* world. But, says Howard, objectivity, reliability, and validity can also be seen as metaphors favored within the culture of science. As such, they are far more suited to describing an object-filled universe than a world of subjects, discriminating according to values and acting from intention.

Howard's point is that stories bring forward or create those elements of experience which are accommodated by the elaborate latticework of metaphor upon which they are founded (cf. Lakehoff & Johnson, 1980; Paré, 1995, 1996; Rosenblatt, 1994). Science therefore provides us with a poor framework for helping to bring forward a person's "agentic self" (Freedman & Combs, 1996, P. 97) because personal agency is not part of the story.

The statement that clients must *change themselves* seems to speak of intention and choice. But in most established therapeutic approaches inspired by the modernist metaphors of science, intention and choice are overshadowed by a clinical stance more oriented to effecting influence *on* persons--ie. correcting their pathologies with psychotherapy and pharmacotherapy. This description closely matches the way in which scientists manipulate the physical world. At the core of these practices, an essential ingredient is missing: the focus on persons as authors of their lives (Freedman & Combs, 1996; White, 1995; White & Epston, 1990; Zimmerman & Dickerson, 1996).

Determined World; Determined Lives

This discrepancy can be traced to the paradigm on which a large body of established therapeutic theory is founded. In the causal discourse of natural science, objects of study don't *act,* they are *acted upon.* A therapy informed by this view construes the therapist as acting upon someone to change them, in the manner that geologists, chemists, and biologists act upon their objects of study. According to this scenario, the *therapist* is the agent, the interventions are *causes,* and clients' changes are the *effects* .

Consider, for a moment, some of the century's dominant psychological stories. They alternately construe persons as compelled by undeniable internal pressures (Freud, 1963), shaped by external contingencies (Skinner, 1971), or as actualizing according to a predetermined developmental tendency towards wholeness (Rogers, 1961). None of these narratives touch on the volitional quality of experience. The notion of personal agency which underrides the claim that it is the task of persons to change themselves is

largely obscured in these stories[4]. They are stories whose metaphorical repertoires are derived largely from physics and biology--disciplines which have virtually nothing to say about personal agency.

A central premise of this essay is that all of this is now changing with the introduction of narrative as a prevalent root metaphor (Sarbin, 1986) in therapeutic discourse. Once widely seen as devoted to the uncovering of essential *truths* and the restoration of *mental health,* the therapeutic endeavour is increasingly construed as an exchange of culturally-imbedded meanings or stories more akin to conversation than to scientific practice (Gilligan & Price, 1993; Held, 1995; Kvale, 1992; Howard, 1991; Mair, 1988; Parry & Doan, 1994).

The narrative metaphor brings forward a range of themes related to personal agency which are obscured by the language and constructs of natural science. In my mind, these themes restore dignity and bestow respect upon persons. They give rise to a sense of hopefulness and possibility, because they ring of self-determination. This essay represents an attempt to underline the crucial importance of *agency, intention, value, choice* and *responsibility* in a therapy informed by narratives ideas, and to demonstrate how these themes are kept at the centre of therapeutic conversations with persons attempting to shed their abusive practices.

The Narrative Metaphor

The narrative metaphor has become ubiquitous among the humanities, including the fields of education, historical studies, linguistics, and literary criticism (Polkinghorne, 1988). This development has not gone unnoticed by the discipline of psychology, ever ready to borrow metaphors from other fields (Rosenblatt, 1994). Held (1995) depicts the prevalence of the narrative metaphor in contemporary approaches to psychotherapy:

> It is noteworthy that many disparate movements within psychotherapy--family/systemic, constructivist/constructionist, psychoanalytic, cognitive, and

> some feminist therapies--have begun to apply a common rhetoric, one that articulates a particular philosophical doctrine: that therapy is a linguistic, narrative, or storied enterprise. (p. 1) [5]

I would amend Held's observation to say that therapy *can be seen to be like* these things. The difference is crucial. As she points out repeatedly in her book, a narrative lens is trained on metaphors, and does not focus on claims about how "reality *is* ". It is not a question of its *truth,* but its *usefulness* that determines a metaphor's worth. Said William James, "truth is the compliment we pay to a few good ideas that work" (quoted in Amundson et. al. , 1994, p.85) Anderson and Goolishian (1988) capture this distinction succinctly, saying that "social science theories are ideologies invented at a moment in time for practical reasons" (p. 373).

Put differently, the intent of this essay is not to argue that persons are "really" agents of their own lives, and that the narrative metaphor is therefore a more precise description of real life. On the contrary, the view of therapy as a storied enterprise can be seen as *itself* a story--a useful narrative defended by reasons of values and utility rather than *truth.*

These ideas are important to the discussion at hand, because this essay is concerned with demonstrating the appropriateness of the narrative metaphor for accessing personal agency (and more specifically, to assist persons in discontinuing abusive practices). Put simply, the narrative view can be seen to construct an alternative therapeutic discourse. It naturally facilitates a view of the person as one who *acts* --an "actor", a word whose Latin derivative means "doer", and whose contemporary meaning suggests "an active agent" (Webster, 1975, p. 20). It is a metaphor which pays more than lip service to the idea that persons who abuse can indeed "change themselves", because they are seen as authors of their own lives, acting out value choices according to intention. I do not intend to defend the "truth" of this view. However, I do advocate for its usefulness.

What Does This Character Want?--The Value Thread

In the sense that I use the term, the narrative metaphor favors a view of experience as a story to be interpreted, rather than a truth to be discovered. In this context, a person might be viewed as a performer of a life story. The connection between story and personal agency became clearer to me through my (limited) experience as a writer of dramatic scripts. In working sessions devoted to putting a developing script on its feet, performers relentlessly quest for the intent which underlies their part by asking What *does this character want?* The needs, hopes, dreams, and ambitions of the characters who inhabit a story are critical to a performer's realizing her or his craft. For an actor, the question "what do I want?" isn't theoretical, but merely practical. To "become" a person, an actor needs to know what that person wants.

This is not an *artiste's* legendary petulance, but an earnest craftsperson's effort to bring the words to life. The dialogue may have a natural ring to it; perhaps even some semblance of plot has formed at this embryonic stage of the script. But the characters have not attained personhood until their values become manifest. Screenwriter Robert McKee (1990) captures this notion succinctly when he suggests that "values are the blood of stories".

Given the current emphasis on the metaphor of the story in a wide range of emerging therapeutic orientations, it follows that values might be viewed as the blood of *client* stories, as well. As the richness and nuance of a person's story emerges, so does a view of the elaborate network of values which inform and give life to their thoughts, feelings, and actions. "When people author their own stories," write Parry and Doan (1994), "they clearly express their own moral perspectives" (p. 46). The question "What does this client *want*?" (as opposed to what, according to an objective and expert assessment, does this client *need*) has therefore become central to narrative postmodern practice.

This is a substantial shift from traditional modalities. A therapeutic orientation which draws heavily on natural science metaphors is inclined to view abusive behavior as aberrance, or dysfunction, which needs correction. This description takes place in

a purportedly objective space wherein human behaviors are categorized as normative or non-normative without reference to their moral dimension. A narrative orientation invites us into the moral domain. When adapting a narrative perspective in working with persons who engage in abusive practices, the clients' moral perspective--the values they wish to retain--become the compass for the therapeutic journey.

Making Choices, Authoring Lives

This shift to a values orientation is another way to characterize postmodernism's segue to a domain of personal agency. Value implies *choice,* and the concept of choice is tied to the notion of agency. Says Reese (1980):

> The concept of value both complements, and stands in contrast to, the concept of fact. One merely *recognizes* the latter, but must *select* the former. For any thing, attitude, ideal, purpose, or goal to be a value, it must be the object of preference, or a judgment of importance. (p. 604, emphasis added)

A therapeutic outlook which draws on a narrative metaphor therefore depicts persons as *players,* rather than *pawns,* in a universal chess game. Like the characters in a play, their personhood is manifest in their effort to create themselves and shape their worlds by seeking to realize their values. Persons are drawn to some things and repelled by others. This inescapable discrimination colors their choices and leads to the shifts in value which add texture and variety to an unfolding story. Viewed in this way, even acceptance in the face of nature's occasionally implacable forces such as organic illness is seen as an act of choice, rather than a deferring to destiny. A narrative metaphor favors a view of life as a creative work of art. "Only in mediocre art," writes Michael Ignatieff, "does life unfold according to fate"(Ignatieff, 1995).

Mckee (1990) says a compelling cinematic story depicts characters enacting value-charged choices under pressure. The description fits for a narrative view of persons in the world. It is not easy to live a story. Stories rock boats. They shake foundations. In opening up new vistas for consideration, they slide the shutters

down (or at least dim the lights) on other views of the world. Stories privilege some meanings over others; they put forward values, they take stands--often in opposition to a dominant cultural story. It is not easy to own one's agency in the world. With choice, comes responsibility.

Restraint and Intention

The narrative metaphor offers an alternative to the view of behavior as the effect of a cause. Instead, our actions are seen as storied expressions of experience which happen in a universe of stories (Parry, 1991). According to this view, which I will explain in more depth in this section, we are *restrained* by contingencies in the expression of our preferred values, rather than *compelled* by causes to act as we do. As indicated earlier, this is not an ontological examination of the true nature of the human condition, but rather an exploration of a way of speaking about our experience. Given that our collective discourse shapes the world of experience we inhabit, it is a way of characterizing human action which promotes responsibility, because it foregrounds the theme of personal agency.

To favor an alternative to causal discourse in the practice of psychotherapy does not imply a view of persons as unhindered by the encumbrances of life. To live a life, to perform a story according to a chosen interpretation, requires courage and persistence in the face of forces much larger than ourselves. Those forces can be seen as narratives themselves. They originate in our families, school systems, governments and media, admonishing us to adhere to the values they espouse, threatening to deny us entry into their club if we fail to conform.

Each of us wakes each morning to extend our story by enacting a new set of choices. We cannot be in the world without differentiating and selecting from a staggering range of potential responses. And yet, we live in a world with limits, and the stories we opt for may not always reflect the values we favour.

White (1982) borrowed the term *restraint* from Gregory Bateson (1972/1987; 1979) to depict the limits we encounter as we attempt to tell our stories, to author our lives. In his more recent

work, White has expanded widely on Bateson's information-systems metaphor to look at how restraints operate according to power dynamics (White, 1993, 1994, 1995; White & Epston, 1990). More than the mere ability to select ideas from nature, the limits to our self-authoring reflect the way some stories are marginalized by institutional forces in society. The stories which dominate, including fundamental conceptions of personhood itself, are the stories promulgated by those who have the power to disseminate and enforce them.

At the risk of doing a disservice to the complexity of an infinite array of dominant narratives in Western societies, they include the stories that 1. Women are born to nurture. 2. Men are inherently competitive. 3. Being smart means getting high grades. 4. Children who won't sit still suffer from a neurological deficiency requiring medication. 5. People sexually abused in childhood cannot form trusting relationships.

When regarded as truth, each of these statements become reified and classified like the components of the natural scientist's world: the biologist's tissue, the chemist's solvent, the physicist's electrical current. For the natural scientist, each of these components is viewed in causal terms, as representative of the real world. But in the domain of psychotherapy, the real world is the world of experience, and experience is what we make of it.

The location of persons in a universe of impinging stories-- rather than truths-- has the effect of creating space for initiating changes which, as the opening lines of this essay indicated, clients are explicitly or implicitly encouraged to make on their own behalf. It is a discourse which sheds new light on the myriad factors which can be seen to be at work in a client's current situation: childhood neglect or trauma, biologically-based conditions, parental upbringing, alcohol and other substances, gender relations, poverty, workplace stress, and so on. All of these make up the fabric of the container in which we live. When they are regarded as restraints, rather than causes, the focus shifts to the person as agent, and therapeutic conversations are energized by the possibility of change.

Staying with the narrative metaphor, restraints are stories restraining stories. The story of the problem we are dealing with, or the stories which others hold about us--even the stories we hold about ourselves--can be seen as "mitigating circumstances" (Zimmerman & Dickerson, 1994) which restrain us from pursuing our preferred paths. Like the actor whose scope is delimited by the parameters of the script, we all experience the restraints on our life repertoires in the socially constructed stories about, for example, what it is to be a man or a woman, to be a "success", to be "normal", to be "a person", etc.[6] Like the actor, we can conceivably violate those ubiquitous prescriptions, but always at a risk. Whereas the actor might be accused of a "questionable interpretation", we might be tagged with the label of "deviance"--or (if we are sufficiently original), "insanity".

Because a restraint is not a "cause" with the incumbent suggestion of determinacy, it manages to depict persons as agents, while at the same time acknowledging the limits of experience. This agency within limits is captured by the metaphor of "recruitment" (White & Epston, 1990; White, 1993). Whether it is a man recruited by the *machismo* myth and a patriarchal ideology into exploitative actions towards women, or a woman who takes up the mother-blaming ideas embedded in our culture to castigate herself for her children's difficulties, the metaphor retains a sense of personal agency. Recruits *act*, even when their performance (like an actor's) is influenced by a prevalent interpretation of the "script" of dominant cultural stories. Recruits respond from volition within a restraining context. They make choices, though some of their choices may ultimately conflict with their values.

The concept of restraints, rather than causes, creates space for alternative ways of being without making indefensible claims to omnipotence. It situates persons in a context of obstacles which may be identified and externalized (White & Epston, 1990), and thus circumvented. The personal agency which accompanies the narrative metaphor is not the "You can do anything!" hype of the motivational speaker circuit. Instead, persons are seen as inhabiting, and being restrained by contexts. And yet, to the extent that those contexts are

conceived as networks of socially constructed beliefs or stories, there remains always the possibility of transcending restraints by re-storying them, or "dis-solving" them through conversation (Anderson & Goolishian, 1988), or "doing something different" (de Shazer, 1991). Says O'Hanlon (1993): "the social reality...is negotiable" (p. 6). There are always possibilities.

Intentions Gone Awry: Brad's Story

Brad[7] came to see me after being told he must either quit or be fired from his job as a clerk in a major corporation, a job which he had held for five years. This pronouncement followed an investigation into Brad's behavior in the workplace--an investigation which culminated in his being charged with sexual harassment.

From my conversations with Brad emerged a picture of a workplace where practical joking was rampant. Workmates would tape signs to each others' back, put vaseline on phone headpieces, and unplug computer keyboards. He talked of how he and other employees, male and female, would tickle each other at the copy machine; of coffee-time conversations sprinkled with sexual innuendo; of men making suggestive remarks over bathing-suited pin-ups within earshot of female workmates.

Among Brad's workmates was Brenda, a woman with whom he confided over coffee in the company cafeteria. Brad told Brenda of his nagging trepidation about being laid off, a victim of corporate downsizing. Brenda shared her experience of being physically abused in a previous marriage. Brad says he was aware Brenda was dating another man, and that he saw her as a friend, not a potential lover. He said he continued to feel that way after Brenda became engaged.

Although Brad and Brenda almost never saw each other away from work, they did maintain ongoing communication through e-mail on the job. Most notes were short and pragmatic--about work details, or about meeting for coffee. Over time, however, Brad began to use the e-mail to tell Brenda of his physical attraction to her. He started by saying he liked the clothes she wore, and the smell of her perfume. But as time went on, the messages became more explicit.

Finally, after reading about how Brad drooled when he imagined her in a bathing suit, Brenda told her boss about the messages. The investigation ensued. Several weeks later, Brad was out of a job.

He came to me befuddled, seeking clarification. Although he had a wide variety of interpretations of the events and his response to them, he was clear he didn't want to repeat the experience. Like many people who have done something they would prefer not to have done, Brad wanted to know "why" he had acted as he had. The implication was that the answer would prevent the unpleasant events from recurring in his life.

The question "why?", like any other question, implicitly carries with it the assumptions congruent with the paradigm or discourse in which it is situated. In the language of this discussion, it might be said that Brad wanted to determine the "cause" of his behavior--behavior which, in hindsight, he saw as abusive. In my work with Brad, I am inclined to decline what Jenkins (1990) would call his "invitations" to construe the events of his life in causal terms. As the description of our work together proceeds, I hope it will become clear that to refuse that invitation is to honour his explicitly stated therapeutic agenda to learn to act more respectfully and responsibly towards himself and others. To facilitate this goal, I in turn invite *him* to construct his situation in terms which bring his own agency to the foreground.

In my conversations with Brad, he touched on a number of factors which he saw as potential answers to the causally-oriented question "Why did I act abusively?" He said he had been physically abused by his alcoholic father--abuse which stopped only when Brad grew strong enough to fight back. He said his "self esteem" had been particularly low during the period he was sending the offending e-mails to Brenda, and that he had a tendency to get "belligerent" when feeling that way. He said the shadow of layoffs at work was highly stressful. Brad also described what he perceived to be a social deficit, an inability to read another person's responses to him. And finally, he pointed to a history of self-sabotage, of "screwing up" just when things were going all right.

What gives these descriptions a causal ring is that none contain the reference to a person acting from intention, making choices, guided by values. As such, they do not even pay nominal tribute to the notion that Brad is now and was then responsible for his actions. True, Brad concluded he was responsible for what had occurred. But a conversation premised on the question "what caused me to do it?" leads down paths which diverge from the metaphor of personal agency, and away from Brad's stated goal of acting more responsibly.

When applied to persons acting in the world, causal description closes conversational space by construing them in much the same way as billiard balls striking each other at precisely calculable angles. Why did the Black Ball go into the corner pocket? The answer is that the White Ball struck it at a 38 degree angle. It makes no sense to consider other places the Black Ball may have gone because the causal paradigm does not allow for it. Given the White Ball's trajectory, the Black ball could *not* have gone anywhere else. Once we determine the path of the White Ball, the conversation is closed. And so for Brad. What caused the Abuse he perpetrated? The question construes the events and actions of his life, like billiard balls, in black and white terms. Within this paradigm, it is tempting to see the answer as equally unequivocal: Childhood Abuse[8].

I do not mean to say Brad and I should skim over a painful aspect of his story and ignore the account of his father's hurtful rages; rather I am suggesting that when we construe his actions in causal terms, we fail to see them as among many *other* possibilities open to a person who makes choices in his life. We attend to the ways in which Childhood Abuse formed Brad the Abuser, like a granite block shaped by a sculptor's chisel. Busy with this task, we fail to notice that Brad *also* interacts with people (including myself) in decidedly non-abusive ways. As a result, we are blind to Brad the Respectful Friend who also sits right across from me.

And so for the other contingencies which Brad described as we explored his traumatic fall from grace. When Brad and I construct Low Self Esteem as the cause of abusively belligerent behavior, we are inclined to "work on" his self esteem--in other words, eradicate the cause, and you eradicate the effect. In the process, however, we

make Self Esteem (rather than Brad, the choosing agent) the locus of control. And while we may have some success together in revising Brad's view of himself, we cannot predict that life's inevitable ups and downs will not lead to a return of that villain, Low Self Esteem. Brendas of the world, *beware.*

Given Brad's description of Stress in the workplace and its role in his hurtful actions, we might work together at devising ways to reduce that causal culprit, Stress. If he is sufficiently appalled with the consequences of his actions, I might advocate (on his behalf) that he avoid Stress at all costs, because of the hazards Stress wreaks on unsuspecting victims, and in turn upon himself. But it saddens me to think of the cloistered way of life Brad would need to adopt in an era where "stress" has become the catchword for the struggles of daily living.

The Inability to Read Social Cues was another candidate for the cause of Brad's abuse. When Brad brought this theme forward, our conversation turned to nature versus nurture. In many ways, that dichotomy serves as an apt metaphor for this entire discussion: it rings of the determinism/free will debate. If our genetic inheritance reigns, then we are determined. If nurture is key, then we are forever changing, and thus retain the possibility of freedom.

This philosophical dilemma is insoluble within the scientific paradigm, which seeks to determine which of the two positions is "true". Nevertheless, science leans strongly towards determinism because it rests on a causal discourse. By definition, a "caused" action is not freely chosen. Narrative's postmodern lens deals with the quandary by abandoning the quest for the truth. If Brad and I construct a picture of him through conversation as a man bound by his God-given deficit, we will support his history of hurtful actions. In a sense, we will promulgate his slavery to his genetic inheritance. On the other hand, if we attend to his ability to discern respectful from disrespectful interactions, he will be far less likely to inadvertently hurt others via electronic mail in the future. To the extent that his future actions will become more aligned with his intentions, Brad will therefore become more "free". But will he, in

reality, be free? "Reality" belongs in another paradigm; go ask a scientist.

A postmodern therapy rests on pragmatism, not truth (Amundson et al., 1994). Rather than attempting to uncover the underlying reality, it turns its attentions to the task at hand. In my work with Brad, the deficit discourse leads us to see his abusive behavior as the evidence of an innate shortcoming. Therapeutically speaking, I experience that road as a dead end.

Brad's final description of Self-Sabotage as the reason for the abuse has more of an agentic ring than the previous purported "causes' because it places a person acting at the centre of the metaphor. But this description has a different sort of problem. It constructs the agent as Brad the Self-Saboteur, whose values are *contrary* to my client's stated goals. Given that Brad and I have come to the mutual understanding that he wants to act more respectfully to himself and others, the Self-Saboteur is not the Brad with whom I wish to talk.

Brad the Self-Saboteur will be inclined to downplay the fact that the man across from me chose to come to therapy because he wanted to do something *for* --rather than against--himself. Discussions with Brad the Self-Saboteur will thicken a plot (Freedman & Combs, 1996; White, 1995) about *dis* respect--a story my client says is not his preferred story. As mentioned earlier, a narrative perspective turns to the values a client wishes to retain as the compass for the therapeutic journey. That metaphor therefore steers me away from colluding with the Self-Saboteur, and instead inclines me to bring forward the voice of the Brad intent on self-nurturance and respect.

Michael White (1994) speaks of persons as having "many wills". To borrow from the billiards analogy, this is like saying the black eight ball can *also* be the seven ball, the nine ball, and even an eggplant (to take the analogy to a slightly silly extreme). The act of choosing transcends causality and the reification of persons that the scientific metaphor perpetuates. We can have many wills, and there can be many explanations for "why" we do what we do. This is what Dickerson and Zimmerman (1994) mean in assuming a person's wish

to hurt "would exist alongside a wish not to feel that way, along with a statement that it does not fit into their system of values and intentions" (p.236).

Brad and I could try to get at the "root" of an apparent wish to hurt himself and others; my guess is we would connect it to his childhood abuse. But this focus on the wish to hurt does not build the preferred plot line, which is about the wish to *not* hurt. As such, it fails to respond to my client's chosen mandate in therapy. An equally unhelpful alternative would be to engage in a search for some iron-clad truth (ie. "Did you intend to hurt, or did you intend to *not* hurt?"). The scientific impulse to uncover what is real can turn a therapeutic conversation into a kangaroo court when it could be the collaborative pursuit of preferred values.

Rather than arguing for the "truth" of a causal or narrative description, White (1995) likes to consider the effects of our ways of constructing problems on the persons with whom we work. A narrative approach to working with persons who abuse is distinguished by the place to which it leads us, by the details we attend to, by our way of speaking. In Wittgenstein's (1963) terms, the narrative metaphor prompts one "language game", and the metaphors of natural science prompt another. My critique of the language game of causal descriptions is not the suggestion it is ontologically inaccurate. Ontology is science's concern; I take my cue from Brad's preferred story. Causal descriptions lead me away from a view of Brad making respectful choices, so I do not see them as helpful in our work together.

To this point, it may seem that I have dismissed Brad's own account of his situation, and of the various life contexts which he associates with losing his job. In fact, he and I have pondered over each of these contexts. However, I believe my task in these conversations is to facilitate movement towards Brad's stated goal of acting more respectfully and responsibly. When Brad construes these various contingencies as the possible reasons for his abusive actions, I invite him to consider them in an alternate manner: as *restraints* on respect, not *causes* of disrespect.

This shift in the way of speaking about Brad's situation leads to a new question. Instead of asking him "What caused you to abuse?", I ask "What made it difficult for you to choose to act respectfully and responsibly?"[9]. More than a subtle change in wording, the latter question brings a new world of experience into being, one premised on the notion of Brad as agent striving to alter his abusive ways.

Jenkins (1990, 1995) applies these ideas with exceptional skill and rigor in his work with male perpetrators of physical and sexual abuse. He begins by assuming that his client would prefer not to have hurt his victim--often his own spouse or child. Like White, Jenkins makes no apologies for what Parry (1995) calls a "sanguine view of human nature". In his work, Jenkins is not interested in debating the "reality" of human nature, in determining if all humans are inherently good. He is intent on ending abuse, and his shortcut to getting there is to invoke the "will to respect", as it were, by assuming it is there. We are far more likely to discover silver linings if we assume they exist. That said, therapy cannot start until the client is engaged. I, too, assumed Brad preferred not to have hurt Brenda; but until he affirmed this, we could not begin the task of ending his abusive practices.

The assumption that the client prefers respectful ways of being leads to the view of disrespectful action as evidence of incongruity between the client's underlying values and their actions, between intentions and outcomes. This is what Tomm (1993) speaks of when he advocates an orientation towards "positive intention"; it is what Parry and Doan (1994) mean when they say that therapeutic conversations are about "intentions gone awry" (p. 3). When working with abuse from a narrative perspective, the task at hand is to join with clients in calling forth respectful intentions--to offer an invitation to responsibility (Jenkins, 1990).

Guided by these metaphors, my conversations with Brad have taken us to many places a person with *dis* respectful intentions would not venture. We have spoken of the ways he learned to act lovingly in a household where praiseworthy relationships did not always prevail. We have explored the upper ranges of the peaks and valleys of his self esteem. We have also talked about those times

when, despite his own low esteem for himself, he has *not* converted those feelings into belligerence with others.

Similarly, we have examined with curiosity how it is that amid unwavering job instability, Brad has sometimes acted with kindness, while at other times choosing hurtful actions. We have also speculated about what Brenda's experience might have been throughout the period of her relationship with Brad. In this, Brad evinced a remarkably subtle account of personal boundaries, trust, and safety which belied all claims to a social deficit . Finally, Brad and I visited and revisited his intentions in coming for therapy, reaffirming his desire for self-respect, and putting aside the description of the Achilles heel of self-sabotage.

At the time of this writing, my work with Brad is not complete. Given the scope of the meanings we have constructed together, I find it unlikely that Brad will engage in sexual harassment in the future. However I do not purport to be offering an example of "successful therapy". Instead, Brad's story serves as an illustration of where therapeutic conversations go when guided by narrative metaphors.

Therapy and Morality

Those metaphors lead to a view of persons acting from a place of agency--not *only* when they are engaged in living preferred stories which they favor, but *also* when they are engaged in abusive practices which they do not favor. This is a wholehearted embracing of our moral responsibility, because it points to the volitional quality of both our preferred *and* unpreferred actions. If we are agents of positive developments, then we must also be agents of unfavorable ones. At least in terms of responsibility, we cannot expect to have our cake and eat it too.

Whereas postmodernism is sometimes construed as dabbling in the dangerous waters of ethical relativity, I believe it faces our moral imperative more squarely than a paradigm founded on causal description. It does this by separating persons from problems, thereby creating space for moral action. As Karl Tomm has said "externalizing the problem internalizes moral responsibility" (quoted by Epston, 1993). When persons are seen as acting from a place of

choice, their efforts to align intentions and actions are inescapably moral in quality.

When therapists engage with clients in the process of co-authoring, they cannot escape joining in the timeless struggle to discern right from wrong. It is a struggle which begins before words enter our repertoires, when a parent chastises a crawling child from upsetting a potted plant: "Bad girl, Caitlin, don't touch!" And so the child enters a moral universe. It is a world where ways of being are assigned values, where parents and other authorities strive to designate these valences in accordance with their moral codes, where growing up involves adopting (and in some cases rejecting) the values of a dominant adult culture.

In this moral context, therapy can be seen as an exchange of value-laden stories in conversation between persons whose lives are both intertwined and differentiated by moral threads which permeate history and culture. Most clients come to this conversation in the aftermath of moral transgressions of various kinds (in some cases they are "victims"; in others, "perpetrators"). Close to home, these may involve emotional, sexual or physical abuse. Further afield, the clash of values may take on a wider scope. It is often difficult to separate the sense of helplessness of a depressed housewife from the mass imposition of patriarchal values, or the bruised esteem of the "failed" businessman from the promulgation of myths of successful manhood. There is always a moral dimension to the struggles of living.

For each of us, the act of re-authoring brings us to value-charged choices that may fly in the face of dominant cultural stories. When we make choices congruent with our values, we risk defying our parents, our teachers, our religious leaders--even the television sitcom producers who insidiously reinforce values of perpetual youth, energy, and good humour.

In his exploration of the theme of moral authority in families, Parry (1995b) suggests values have taken a "bad rap" in this century, to the extent that calls to responsible action are frequently invalidated as "guilt-trips". Parry argues that this suspicion of the moral voice is largely shared by the therapeutic community, so that

"the introduction of questions of moral obligation into a clinical matter tends to be seen as irrelevant at best, seriously problematic at worst, but almost never as potentially conducive to emotional well-being" (p. 3).

The therapeutic work described here is founded on a very different premise. Through its embrace of personal agency, the narrative metaphor inevitably leads therapeutic discourse precisely *into* these questions. To promote a preferred story is to help a person align intention and action. This is impossible without asking, over and over again, "what are my values?"

But it is not just our clients who are busy with these moral concerns. To do therapy is to enact therapeutic values. As Tomm (1988) says, "every question asked by a therapist may be seen to embody some intent and to arise from certain assumptions" (p. 1). Even an intervention as simple as an absorbed silence which invites further elaboration from the client reflects a value--it represents the therapist's choice to stay here rather than move to another place of affect or an alternate range of ideas.

A narratively-oriented therapy rests on values. It does not depend upon pre-conceived normative templates for mental health and human development which in turn are depicted as resting on unassailably *objective* criteria. Objectivity keeps us out of a moral domain. Narrative wears its subjectivity on his sleeve: people are entitled to respect, and it is important that we act in responsible and accountable ways.

If performing a life involves a series of value choices, *so does therapy*. From such a position, "therapy is inescapably a moral endeavour" (Freeman & Lobovits, 1993, p. 190). As Bird (1995) points out, this is no easy matter: to engage in respectful relationships, to practice psychotherapy--both are acts which call for moral courage.

Footnotes

1. Throughout this essay I will make reference to "metaphors" in discussing our ways of understanding and talking about the world.

This terminology reflects a wide constellation of postmodern ideas about how language relates experiences to each other, rather than representing an underlying reality. For more on these ideas, see Lakehoff & Johnson, 1980; Paré, 1996; Polkinghorne, 1988; Rosenblatt, 1994, as well as the body of work by Jacques Derrida.

2. It is important to note that this discussion is devoted primarily to locating work with abusers within a narrative theoretical model. Although I draw on a clinical example to illustrate the ideas, the reader is directed elsewhere (cf. Durrant & White, 1990; Freedman & Combs, 1996; Gilligan & Price, 1993; Jenkins, 1990; White, 1995; Zimmerman & Dickerson, 1996) for more detailed descriptions of the ideas in practice.

3. See the third essay in this collection for a detailed discussion of law-based versus culture-based description or knowledge.

4. By this I do *not* mean to suggest that practitioners working from these orientations do not attend to their clients' intentions and choices. But in doing so, they step out of their guiding theoretical frames. In a sense, they must go against the flow of the metaphors informing their work in order to make visible their clients' agency.

5. In this discussion, I adhere to Held's use of the term "narrative" to describe a broad range of contemporary approaches to therapy, and not exclusively "narrative family therapy" as it is often equated with White and Epston's work (1990).

6. An underdeveloped theme in narrative discourse pertains to a different range of "stories" which also restrain us--the stories of the body. We are also restrained in our own embodiment. But *that* (as they say) is another story.

7. In this essay, I have changed the names of the persons mentioned and some of the details of their situations in order to protect their confidentiality.

8. In this section, I have chosen to capitalize purported causes and effects to capture the way in which they become reified in causal discourse.

9. In practice, I may never use these precise words. In a sense, this question respresents the questions which reflect this guiding curiousity.

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CHAPTER FOUR:

Cultural wisdom: Reflections on knowledge and accountability in postmodern clinical practice

"The particular eternally underlies the general; the general eternally has to comply with the particular."
(Goethe, quoted in Smith et al, 1995, p. 59)

"A barbarian...[is] one who thinks the customs of his tribe and island are the laws of nature."
(George Bernard Shaw, Caesar and Cleopatra)

Mark Noyer's mother drove off with her boyfriend when he was six years old, and never came back. Now 45 years old, Mark is married to Norene, 44, and has two children--Angela, 16, and Brian, 14. Mark is a heavy drinker who becomes verbally--and occasionally physically-- abusive with is wife. He says she does not reserve enough affection for him and typically blames her "cold withdrawal" for his drinking problem. Norene covers for her family by making phone calls when Mark is unable to report for work, pay bills, meet family commitments etc., due to inebriation or hangovers. Norene attends formal meetings with other spouses of problem drinkers, but appears almost indifferent to her husband's behavior. Her energies are focused primarily on raising their two teenaged children. Angela and Brian are verbally inexpressive. They invite few friends home due to their father's drinking, in which he now indulges on his own, often using vodka because its odour is easily disguised.

Though their names have been changed, the story of the Moyer family is drawn from clinical experience, and presents a vital dilemma inherent in the practice of family therapy. As this essay unfolds, I shall discuss how that dilemma has been thrust into sharp relief as postmodern ideas occupy a greater place in therapeutic discourse. It is about the place of knowledge in the therapeutic encounter, and about how one might engage in acountable therapeutic dialogue which makes room for the knowledges[1] of both clients and therapist.

Mark and Norene's vignette depicts one family's story; but my experience as a family therapist accustomed to hearing a wide array of life stories suggests it could almost be "generic" to a familiar presenting problem. Though the details are hung on *particulars* , they speak of *general* patterns of behavior and experience common to a range of families dealing with the influence of alcohol.

Meeting the Moyers in a therapeutic context, we become acquainted with their distinct practices of self and relationship, thereby acquiring particular knowledge about this one family. We come to this meeting with knowledge of other families we have encountered professionally and personally. As clinicians, we draw on these various domains of knowledge in our efforts to be helpful to the Moyer family. The question of which knowledges to attend to, how to construe them, and the weight to ascribe to them, is an important one at a time when the knowledge claims of contemporary psychology are under critical scrutiny (Denzin & Lincoln, 1994; Guba & Lincoln, 1982, 1994; Kvale, 1992; Polkinghore, 1988; Schwartz & Ogilvy, 1979; Smith et al, 1995a, 1995b; Spence, 1982) and when there is heightened attention to the potential for misusing professional knowledge in ways which are disempowering or even oppressive (Amundson, Stewart, & Valentine, 1993; Amudson, Parry, & Stewart, 1994; Freedman & Combs, 1996; Kearney, Byrne, & McCarthy, 1989; Todd & Wade, 1994, 1995; Tamasese & Waldegrave, 1990, 1994; White, 1995).

On the one hand, we may attend to the data directly before us: the idiosyncratic details constituting the *particulars* of the Moyers' story which render their experience unique. Following on this orientation, we might adopt a "not knowing" stance (Anderson 93, Anderson & Goolishian 90; Freedman & Combs, 1996; Griffith & Griffith, 1992; Hoffman, 1991), deliberately excluding pre-understandings and expert knowledges so that we priviledge the family's meanings.

On the other hand, we may revert to a *general* view of the case at hand, extrapolating from the data before us and viewing the family as an instance of a group: in this case, a group composed of families dealing with alcoholism, parenting of teenagers, childhood abandonment, and so on. We might turn to the literature on 1) alcoholic families (cf. Black, 1984; Schaeff, 1986; Steinglass et al, 1987) to further understand the Moyers' interactional dynamics; 2) childhood loss and alcohol abuse (cf. Tennant & Bernardi, 1988) for a broader view of Mark's relentless demands for more affection; 3) the family life cycle (Carter & McGoldrick, 1988; McGoldrick, 1982)

to shed light on Norene's reluctance to attend to her own needs at a time when teenaged children are still living at home. We might also consult the DSM IV (American Psychiatric Association, 1994) for further normative data on the family's presenting issues.

Fraenkel (1995) suggests that family therapy has been "catapulted" into this debate about the general and the particular--a debate about whether the field "should accumulate and apply knowledge about patterns of adjustment that hold across different families, or whether the field should consider each family as unique, and should tailor interventions solely on the basis of these unique qualities" (p. 113).

This dichotomy between these views--sharply drawn here for the purposes of underlining the distinction--is much deserving of attention in the responsible practice of psychotherapy. It is also a distinction central to the postmodern debate. In broad terms, the downplaying of reliance on generalizations--on appeals to "expert" knowledges and pre-understandings--with a corresponding emphasis on "local knowledge" (Geertz, 1983), can be equated with a range of emerging postmodern therapeutic practices (Anderson & Goolishian, 1988; Epston & White, 1992a; Freedman & Combs, 1996; de Shazer, 1991, 1994; Gilligan & Price, 1993; Hoffman, 1993; Hoyt, 1994, 1996; McNamee & Gergen, 1992; Monk et al., 1996; Paré, 1995, 1996; Parry & Doan, 1994; White, 1995; White & Epston, 1990; Zimmerman & Dickerson, 1996). These approaches emphasize the uniqueness of persons and the importance of meeting clients with a disposition variously characterized by "beginner's mind" (Epston, 1996), "curiousity" (White, 1988), and "misunderstanding" (de Shazer, 1991). From this point of view, the client is the expert, and the therapist's role is to bring forth that expertise.

In contrast, the attention to general, rule-based knowledge derived from accumulated cases beyond the immediacy of the clients at hand is more representative of practices associated with modernist assumptions. The vast majority of psychological literature to this date reflects these assumptions, which are founded on empiricism, logical positivism, and other founding metaphors of natural science (Polkinghorne, 1988, 1994). In contrast to

postmodernism, which emphasizes the uniqueness of each context (and person), modernist approaches typically search for the commonalities between persons: they rely on general theories and view individual cases as specific instances of general principals.

In the course of this essay, I will explore this particular/general dichotomy in some detail. I will propose a dialogic orientation to therapy that is much informed by a postmodern ethos, but is more than simply "not-knowing"–a therapy that makes room for knowledges transcending the particulars of the case at hand *without* construing those knowledges as universal laws, of which the family at hand is a prototype. In other words, I will advocate for viewing the general knowledges which clinicians bring to each therapeutic encounter as context-bound understandings which facilitate therapeutic dialogue. I introduce the term "cultural wisdom" for these understandings, reflecting Bruner's (1990) observation that "human beings don't terminate at their own skins; they are expressions of a culture" (p. 12). We inevitably carry that culture to the therapeutic encounter. But, as I shall argue, the knowledge gleaned from our cultural contexts is more appropriately seen as grist for the conversational mill, rather than a repertoire of totalizing pronouncements about human change processes.

Following on these ideas, I will further suggest that the more important question about drawing on any knowledges is not which is *true*, but rather, which is *useful* for the persons with whom we are working. In effect, I will propose that choices about which knowledges to attend to, and to which degree, are always *ethical* choices, and that a responsible orientation to the particular and the general demands constant monitoring, in order to promote accountability.

Knowledge is a foundation of competence; it lies behind the power to envision new possibilities and effect change. Knowledge also grants influence and control, and the authority to subjugate and silence. The question of how to be helpful to the Moyer family concerns the domains of knowledge to which we as therapists attend, the manner in which they are conceptualized, and the weight we ascribe to them in our work with clients. One can therefore view the

therapist's ongoing task as a series of critical choices regarding the application of knowledge. Upon *whose* knowledge is change constructed; *what* sense is made of the knowledge; *which* knowledge is relevant; *how* is the knowledge invited into the therapeutic conversation?

These questions are of enduring relevance to us as family therapists. When knowledge and power are understood to be inextricably linked (Foucault, 1980), questions about the use of knowledges in therapy touch on the issues of power and exploitation. In this essay, I will explore the questions both pragmatically and ethically as we reflect on the accountable use of knowledge in the therapeutic encounter.

Knowledge and the Postmodern Critique

This discussion about knowledge and its use is inescapably rooted in the context of the paradigm shift now underway in the field of psychotherapy (Paré, 1995). Increasingly, traditional claims to the truth status--or even the more modest corrolaries of "validity" or "reliability"--of empirical findings are falling into question (Denzin & Lincoln, 1994; Harré, 1981; Kvale, 1992; Polkinghorne, 1988; Smith et al., 1995a, 1995b). Where "knowledge" has traditionally been equated with universal "laws of nature" uncovered by rigorous research methodologies, there is now a growing emphasis on knowledge as culturally embedded, socially constructed meaning (Bruner, 1986; 1990; Gergen, 1985, 1991; Gergen et al., 1996). According to this view even science itself, traditionally viewed as the repository of context-free truth, is regarded as a body of "culture tales" (Howard, 1991) reflecting the constricted assumptions upon which it is founded[2].

This epistemological shift has clear implications for psychotherapy. It tempers the clinician's sense of "expertise" when that expertise is seen to be a construction of a particular professional culture reifying a select set of knowledges. Where once it may have been equated with insight into "truth", psychological expertise is now widely regarded as a contextualized form of knowledge which enjoys a special status "and is often used as a vehicle which

reproduces cultural expectations and social norms" (Madigan, 1996, p. 51). Or, as Polkinghorne (1994) puts it, knowledge is *rhetorical*: "all knowledge is a knowledge claim".

In other words, clinicians' knowledge, including their theories, both reflect their cultural origins and promote those cultures' agendas. They do not merely represent the "facts" about the human animal. In what context was the knowledge generated, and to what degree is it relevant and useful to the culture (ie. family) at hand? From this perspective, the notion of "expertise" founded on accumulated professional knowledge does not so readily imply a benevolent attribute. It depends how you use it.

Therein lies a central premise of this discussion. Knowledge claims can always be refuted; the more important questions about any knowledge is not "is it true?", but rather "how can it be used in ways that are useful and accountable?". Poorly handled, even a little knowledge can be a dangerous thing. The "expertise" I advocate is more concerned with the pragmatics and ethics of relationship than with truth status. This notion should become clearer as the discussion proceeds.

There was a time when a clinician might perform an intervention with the steady-handed self-assurance of a surgeon wielding a scalpel. However, therapy much less resembles medical science than we have come to believe in a century prone to the adulation of science and technology. Given the growing emphasis on meaning and interpretation in the human sciences, the "scalpel" of a therapeutic intervention might be roughly equated with a cultural belief. Following on this, the imparting of expert therapeutic knowledge can be seen as akin to colonization (Amundson et al., 1993; Kearney et al., 1989; Todd & Wade, 1994, 1995), with a slip of the scalpel risking cultural assimilation. Psychotherapy is a high stakes game.

Returning to Mark and Norene, we are reminded of the responsibility inherent in the act of attending to the various knowledges which inform our interactions with their family. The Moyers themselves can be seen as a culture unto themselves (Paré, 1995, 1996a), in that they make meaning of their worlds, like all

families, with an exquisite idiosyncracy which reflects their unique origins. Given the familiarity of the family's situation, it may be tempting to extrapolate from the particulars of their situation and construe them as prototypical examples of a generalized group: the "alcoholic family:, for example, or the "codependant couple". But to do so risks obscuring their meanings, thus obstructing their ability to construct their lives.

In Search of Dialogue: Seeking Detente

I am greatly encouraged by the proliferating traffic in ideas which support these sentiments, by the growing emphasis on psychotherapy's hegemonic potential. I believe modernist psychology has tended to overlook the richness of the particulars at hand, the primacy of the individual or family's story, by regarding the contextually embedded instance as merely "a moderator or qualifier for theoretical positions of a more general scope" (Gergen et al., 1996, p. 496). This near dismissal of local knowledge reflects the natural science tradition of granting elevated prestige to universal laws which guide practice--a tradition which places theory before experience.

However, I do not believe the only alternative to these totalizing practices is to therefore dismiss the relevance or usefulness of professional knowledges. Instead, I will discuss ways of viewing professional knowledges, and introducing them into therapeutic conversations, in a manner that attends to the concerns raised by the postmodern critique without jettisoning the possibility of accumulating useful skills and experience through ongoing clinical training and practice.

Postmodernism's swing of the conceptual pendulum reconstrues the therapeutic process: where formerly it was dominated by an expert therapist, now it is seen to be the domain of the expert client. The conception of persons as experts on their lives is nothing short of glorious; but not if it dismisses the consideration of the *other* party's (ie. the therapist's) expertise in a therapeutic converation. Without this, I wonder, where is dialogue?

The thoughtful critique of therapy's colonial legacy (Amundson et. al., 1993, 1994; Todd & Wade, 1994, 1995) risks obscuring the *sharing* of knowledges that inevitably takes place in all therapeutic encounters (a sharing which, ironically, is highlighted in the postmodern emphasis on therapy as the *co-construction* of new meanings by therapist and client). Clinicians with experience around issues of loss and alcohol abuse should be able to draw on their knowledges in their work with the Moyers while simultaneously honouring the primacy of the family's experience. As this discussion unfolds, I will propose a means of situating general knowledges so that they may take their place in a dialogue that honours clients' uniqueness without discounting the experience and knowledges of others, including the therapist.

This essay therefore seeks a *detente* of sorts. It seeks a place of compromise that makes room for both bodies of literature and domains of knowledge cited at the outset--for a not-knowing stance which priviledges the immediate context, the family's story, but which also invites the consideration of other contexts and stories which might enrich the conversation at hand. And I will discuss a range of accountability structures which help to ensure that whatever knowledges are drawn upon in the therapeutic endeavour, it is done so in a way which honours the primacy of our clients' experience.

In order to explore these issues further, it would be useful to clarify the distinction between particular and generalizeable knowledge by introducing a less colloquial, but related, pair of terms first used by the German philosopher Wilhelm Windelband almost a century ago.

Laws versus Cultures: Nomothetic and Idiographic Knowledge

One way to view the clinical decisions posed by the Moyer family, and indeed by all clients, hinges on the distinction between generalizeable, cross-contextual knowledge versus particular, context-specific knowledge. Windelband (1904) introduced the terms *nomothetic* and *idiographic* to delineate these forms of knowledge.

For Windelband, the term *nomothetic* implied "based on law". Nomothetic knowledge tells us about *what always was (was immer ist)* -- what is recurrent across particular instances (Lamiell, 1995). In Windelband's sense, *idiographic* knowledge ("based on the particular individual") can be contrasted with *nomothetic* knowledge in that it does not purport to describe universal law, to what always was and will be.

Allport (1937/1971) adapted this same distinction in his wide-ranging studies of human personality. Writing at a time when the scientific worldview more securely dominated the psychological landscape, he favored a broad approach to psychology which made room for both particular and generalizeable description--for the idiographic and the nomothetic. However, Allport found the psychology of his day, though ostensibly a "human" science, to be primarily preoccupied with nomothetic formulations:

> [the nomothetic disciplines] seek only general laws and employ only those procedures admitted by the exact sciences. Psychology in the main has been striving to make of itself a completely nomothetic discipline. The idiographic sciences, such as history, biography, and literature, on the other hand, endeavour to understand some *particular* event in nature or society" (p. 22, emphasis in original)

Allport was disturbed by the dominance of the logico-scientific thread in psychology and the corresponding privileging of the nomothetic over the idiographic. He argued that the single-minded quest for generalizations leads to a view of the individual "only as an *instant* or *example* of a universal principle; the search is always for broader and more inclusive formulations" (Allport, 1937/1971, p. 4). Writing wrily of this dilemma in an era when an idiographic emphasis was widely regarded as falling outside of the jurisdiction of psychology proper, Allport said the "sciences find the very existence of the individual somewhat of an embarrassment and are disturbed by his [sic] intrusion into their domains" (Ibid, p. 3).

The distinction between the nomothetic and the idiographic relates to the issue of *sameness* and *difference* between individuals or groups. Sometimes referred to as the universalism/relativism

duality (Fraenkel, 1995), it is a distinction much debated in cross-cultural studies. Pedersen (1991) describes the debate between proponents of an "etic" or universalistic view favoring the culture-general characteristics that unite and those who favor an "emic" emphasis on cultural relativity--on the culture-specific characterisists that differentiate.

The nomothetic/idiographic distinction is reiterated in a slightly different guise by Hare-Mustin (1986), who points out a similar etic/emic duality in psychotherapeutic theory as it pertains to men and women. She argues that a systemic orientation downplays the differences between the genders, adapting what she calls a "beta" bias, whereas psychodynamic theory displays an "alpha" bias by exaggerating the differences between women and men. These latter examples are not articulated in Windleband and Allport's terminology, but they also touch on the relevance and usefulness of particular and generalizeable knowledges.

Although Allport's individual psychology had all but disappeared from the psychological repertoire by the end of the 1950's (Polkinghorne, 1988), his early musings on the nomothetic/idiographic distinction now appear strikingly prescient. The much debated issue (Fraenkel, 1995; Hare-Mustin, 1986; Pedersen, 1991; Smith et al., 1995c; Smith and Heshusius, 1986) exemplifies the underlying tension between modern and postmodern perspectives.

It is not surprising to me that the field of psychotherapy is currently engaged in this debate. In Windleband's original usage, "nomothetic" was applied to the natural sciences while the term "idiographic" was reserved for the human sciences. Polkinghorne (1988) suggests that psychology jumped on the natural sciences bandwagon some time before the turn of the century, and the field's growing interest in postmodern ideas is an attempt to reallign itself with human science traditions. Psychology's ongoing segue into postmodernism can therefore be seen as a flourishing interest in idiographic knowledge, with a corresponding re-evaluation of the nature and value of nomothetic precepts.

This trend is certainly evident in the research domain, where the proportion of qualitative studies (generally inclined towards idiographic data) versus quantitative studies (which most typically reflect a search for nomothetic description) is steadily increasing. In clinical practice, this heightened emphasis on the idiographic is reflected in the previously mentioned proliferation of literature on context-focused, social constructionist approaches.

A postmodern orientation to therapy shows an "interest in detailed understanding and description of the individual case; valuation of the verbalized experience...of the subjects of clinical inquiry; and mistrust of statements meant to characterize families in general" (Fraenkel, 1985, p. 117). Broadly speaking, modernist practice is drawn to a contrary interest: it engages in a *quest for those very generalizing statements, expressed as laws* (Harré, 1981).

Modernist practice is more inclined to attend to context-specific data only insofar as they help to identify the class of which the particulars at hand are members. Following the Platonic tradition of viewing nature as a mirror of reality (Rorty, 1979), it views particulars as trace evidence of universal truth. Underlying this stance is a belief in the uniformity of nature--that the "stuff" of the world is essentially the same, regardless of the context in which it is found (Lincoln & Guba, 1985), an assumption that "since we are all human, we are all fundamentally alike in significant psychological functions; and cultural (or social) contexts of diversity do not affect the important 'deep' or 'hard-wired' structures of the mind" (Much, 1995, p. 99). Stigler, Shweder, & Herdt (1990) refer to this as the belief in an "intrinsic psychic unity" of humankind (p. viii).

Despite these bold brush strokes, I do not mean to suggest there is a sharp either/or distinction clearly delineating any one person's practice along either postmodern or modern lines. For the purposes of explication, though, it is useful to render more vivid a complex dichotomy. In more colloquial terms, that nomothetic/idiographic dichotomy can be described as the distinction between *law-based* versus *culture-based* knowledge. Nomothetic formulations purport to transcend cultural context, whereas idiographic description deliberately locates itself in the

particularities of the context (or culture) at hand. And so my broad summation of this distinction vis a vis psychological practice is as follows: modernist practice typically construes clinical and other knowledges as law-based, while postmodern practice views them as culturally-imbedded (see Table 1).

Like Smith and colleagues (Smith et al., 1995c), I believe the emphasis on cultural context "has been grossly neglected in mainstream psychology" (p. 59). I advocate for a culturally-inclined therapy, but prefer to hang onto the baby while draining the bath water. As we shall see, this essay seeks to describe a practice which privileges the particulars at hand while still drawing on those knowledges accumulated over more than a century of (primarily law-based) research and practice.

Probabilities and Persons

Law-based description seeks patterns which occur across time and place. Once established, these patterns form the basis for prediction. Consider the example of John, a 12 year old boy offered as an illustration by Allport (cited in Smith et al., 1995c).

John grew up in the slums, the son of a criminal father and a rejecting mother. Allport asks us to suppose that research shows 70 per cent of boys with a similar background become criminals. This pattern of delinquency, statistically rendered, is the nomothetic description of John. It regards him as an instance of a group or class and is founded on probabilities. As Allport points out, the particulars of John's life, the idiosyncratic manner in which he constructs himself and his world, are not part of this description. In effect, John is viewed as the manifestation of a theory about slum environments, young boys, and delinquent behavior. A law-based, nomothetic perspective privileges generalizeable models and theories, which are themselves "logically ordered sets of laws...reduced to a logical apparatus necessary to the business of prediction." (Harré, 1981, p. 3).

Allport suggested a preoccupation with law-based formulations obscures our view of individual personality by rushing to identify the general without attending to the particulars from which the

general is derived. He felt the statistical account of the behavior of John-like persons (for want of a better term) failed to capture John himself. "Does this mean that John himself has a 70 per cent chance of delinquency? Not at all...there is no 70 per cent chance about John. He either will or will not become delinquent" (Smith et al., 1995c, p. 62.).

A therapy guided primarily by a law-based view objectifies persons, and construes them as the products of causal determinants. It also contravenes what would seem to be a fundamental underlying premise of therapy--that persons may transcend restraining contingencies and enact meaningful changes in their lives. If John is a probability, or the effect of environmental and biological causes, then what is the utility of engaging in a therapeutic conversation with him?

The therapeutic disposition I am here advocating is akin to what Bruner (1990) calls a "cultural psychology". It supposes that persons cannot step *out* of culture into some rarefied place where universal law reigns supreme and determines "behaviors". Bruner argues that while seemingly universal contingencies such as our own embodiment may constrain us, it is our cultural meaning-making which plays the more important role in determining the limits to our experience. This makes sense to me. And so I am here concerned with exploring the place of knowledge in therapy not in terms of transcending culture, but rather to understand how the cultural formulations we bring to our work can both help and hinder the process of psychotherapy.

Two cultures meet when therapist and client(s) come together[3]. I have already alluded to the well-articulated critique of psychotherapy's colonizing proclivities, to the power of one dominant story to subjugate another. A cultural metaphor introduces an important cautionary note to the work of therapy. The dilemma posed here is how we may heed this caution, and avoid obscuring the particulars of our clients' cultures while still drawing on the knowledges and understandings accumulated within our own culture.

I do not believe a sharing of knowledges *inevitably* entails assimilation of one culture by another; there may also accrue mutual

benefits when cultures share their knowledges. In some cases, the therapist who shares knowledges with clients may be like the aid worker who brings medicine to fight disease, ploughs to till the land, lumber to construct shelter, art materials for expressing creativity, and so on.

What, then, distinguishes knowledge as a vehicle for cultural subjugation from knowledge as a tool for expanding possibilities? I believe the distinction hinges largely on the nomothetic/idiographic dichotomy--on the distinction between law-based and culture-based knowledges. Law-based description proclaims, in effect, that such and such is the case for all individuals in a class across cultural boundaries. In Karl Tomm's terms, it "sets forth" rather than "brings forth". In doing so, law-based description closes down dialogue between cultures by reifying one culture's (the therapist's) meanings. A cultural view of knowledge avoids that totalizing impulse, and approaches practice more on a case-by-case basis. Culture-based description, by definition context-specific, wears its origins on its sleeve. It follows naturally that when knowledges are viewed as culture-based, they are offered more tentatively, to be evaluated for their usefulness in the context in which they are received.

Polkinghorne (1993) suggests that contemporary practitioners, and especially more experienced ones, tend to operate in this idiographic manner--despite the nomothetic tenor of most theoretical systems upon which they base their practice. In effect, they rely less on that warehouse of law-based thought, the academy, and more on their own experience, or what Yeatman (1996) calls "practical wisdom". Put differently, Polkinghorne suggests that seasoned clinicians learn more from experiences within their cultural domain than from purportedly cross-contextual, law-based proclamations about clinical populations and practice. The knowledge they rely on is gleaned *not* from general principles, but from a wide range of specific encounters with individuals and families. In order to emphasize that the experience they draw from is inevitably context-bound, derived from the clinical culture of therapy, I have modified Yeatman's term, referring to clinical knowledge as "cultural wisdom"[4].

Cultural Wisdom: An Epistemology of Practice

Polkinghorne (1993) draws on a range of survey studies to describe an ongoing discrepancy between what law-based research recommends by way of clinical practice, and what therapists actually *do* when they sit down with their clients. The difference is that the research appeals to generalizations, while clinicians evince a "belief in individual differences and the need for particularized understanding" (p. 155).

Polkinghorne calls this clinical orientation the "epistemology of practice", and he sets it apart from the epistemology which still drives much academic research. In effect, he is saying the shift I advocate here--a shift towards a cultural from a law-based orientation--is *already* taking place as clinicians increasingly adopt what is sometimes called a "neopragmatic" stance reflective of postmodern thinking:

> Neopragmatism shifts the focus of knowledge generation from attempts to describe the real as it is in itself (theoretical knowledge and 'knowing that') to programs to collect descriptions of actions that have effectively accomplished intended ends (practical knowledge and 'knowing how'). Pragmatic knowing concentrates on understanding *how* to, for example, ride a bicycle, rather than on knowing *what* laws of nature allow the bicycle to remain upright. (p. 151)

Notice that unlike rule-bound knowledge, pragmatic knowledge is not founded on laws, but rather individual instances. This is essentially the nomothetic/idiographic distinction expressed in parallel terms. Polkinghorne (1994) says law or rule-based (ie. nomothetic) knowledge is founded on a classical model of categorizing which constructs a prototype, and compares individual instances to that prototype. This model compares the Moyers to the prototypical "alcoholic family", or John to the "delinquent slum kid". Pragmatic (ie. culture-based or idiographic) knowledge, on the other hand, is based on what he calls an "exemplar" model. There is no single reference point, but a series of exemplars: related cases, or narratives.

For Polkinghorne, a neopragmatic orientation does not imply dispensing with science, but "instead of being a search for underlying laws and the truths of the universe, science serves to collect, organize, and distribute the practices that have produced their intended results" (p. 152).

Because it is founded on real-life instances rather than extrapolated generalizations, neopragmatic knowledge is less exact, grayer around the edges. In my view this is preferable, because it renders it closer to experience. It is always unfinished and in need of revision, holding "that each situation is different and contains the uncertainties of its specific location and time" (Polkinghorne, 1993, p. 152).

As mentioned, Yeatman (1996) uses the term "practical wisdom" to describe this idiographic, pragmatically oriented knowledge. Like Polkinghorne, she is unapologetic about its tentative nature:

> The therapist may discern in her client the symptoms of a particular type of family history and its pathology. However, this discernment is of orienting value only, and it may prove to be a partial lead at best in relation to the delicate intersubjective process of coming to some kind of shared understanding between therapist and client...the hallmark, then, of practical wisdom or knowledge is its ability to recognize and respond to the uniqueness of each subject". (p. 8)

Both Yeatman and Polkinghorne describe practices informed more by narrative ideas than logical positivism. Practical wisdom evokes something like the "not-knowing" stance mentioned at the outset, but with an important difference. Rather than regarding the therapist's knowledges as unworthy of inclusion because they originate in a different context, those knowledges are considered tentatively helpful, subject to verfication by checking them against the particulars at hand. This checking is a feature of what I would call respectful conversation. For as Polkinghorne (1993) says, "the epistemology of practice maintains that it is a mistake for a therapist to universalize his or her experience as applicable to all clients in all situations" (p.160). Yeatman (1995) makes the same point, saying

practical wisdom promotes "questioning in the spirit of ongoing and dialogical research rather than as one which invites authoritative points of closure in the form of an answer" (p. 4).

Like narrative research (Clandinin & Connelly, 1994; Connelly & Clandinin, 1990), a practice informed by a culture-based view of knowledge calls for mutuality and collaboration between therapist and client. This is perhaps most fully realized when service providers and service users pool their knowledges and arrive, through dialogue, at a mode of treatment (Yeatman, 1995). In the terms of this discussion, this is akin to the collaboration between two cultural groups, in which the practices which emerge are reflective of the values and beliefs of each. Madigan & Epston (1995) engage in this process with clients (more properly construed as "co-researchers" in this context) through their formation of "leagues" of persons dealing with anorexia. I will say more about these practices when I address the issue of accountability.

Although this discussion is located largely in the abstract discourse of epistemology, the differences between a law-based and a culture-based orientation are concrete and palpable in the microcosm of each therapeutic moment. Consider the Moyers. Listening with a law-based bent, I will seek out symptoms which will help to determine the categories of which family members are representative. When Mark tells me about waking up hungover and phoning in sick, when Norene describes finding vodka bottles in the recycling bin, I will hear the symptoms of "work absenteeism" and "covert drinking" which suggest to me the category of "alcoholic".

Once Mark is "pegged" in this way, I may begin to let go of my curiousity about what makes Mark unique, turning my attention instead to my accumulated professional knowledge regarding alcoholism. Indeed, I may immediately trot out a comprehensive treatment plan which I have utilized for some time with other alcoholics--a plan with rigid prescriptions for total and immediate abstinence, the breaking down of denial, revision of belief systems, etcetera. This nomothetic inclination is equally present when we gauge a child's capacity based on a Piagetian principle of child development, when we locate a grieving widow in a stage of loss, or

when we predict the capacity for a sexual abuse survivor's prospects for forming trusting and enduring relationships.

I do not mean to suggest that the knowledges which inform any of these acts should be summarily dismissed, however; and therein lies the subtlety of this argument. A culture-based epistemological stance does not require that we throw out our knowledges, but rather that we construe them differently, and therefore introduce them into the work in a more tentative and open-ended fashion. Meeting the Moyers from a culture-based view, the stories of hangovers and secretive drinking will be, as Yeatman says, of significant "orienting value". They are familiar *patterns*, and patterns direct us from the story at hand to other stories. A culture-based stance does not limit us to the particulars; it prompts us to draw upon other stories in order to make sense of the case in point. The Moyers' anecdotes speak of alcohol abuse, and they will incline me to connect with a myriad of knowledges I have accumulated from work with previous clients.

These are the "exemplars" of which Polkinghorne (1994) writes. They are related narratives--stories of the successes and failures of other families grappling with substance abuse--which the Moyers and I may both compare and contrast with their own predicament. These knowledges derived from my "culture" may thus be invited into our conversations without having to provide the blueprint for unilateral interventions founded on my expertise.

Regarding my knowledge as culture-based rather than law-based, I ask questions and share anecdotal material in a manner more tentative than certain. Far from heralding a clinical defecit, this tentativeness opens space for the Moyers to tap in to their own expertise with the aid of additional knowledges, rather than submitting to what they might perceive as an expert's better judgement.

I believe an orientation to knowledge founded on cultural wisdom rather than clinical certainty goes a long way towards addressing the possibility of both 1) privileging client meanings, thus circumventing therapy's colonizing tendency; and 2) making space

for therapist knowledges, both personal and professional. To review, it does this in a number of ways:

1. It grants primacy to the particulars (ie. the culture) at hand--to the details and nuances of the client(s)' story.
2. It views each client as unique, rather than referencing them to a prototypical, rule-bound model.
3. It maintains a cultural sensitivity, regarding knowledges as contextually imbedded, and thus not always amenable to cross-cultural (ie. therapist and client) translation.
4. It characterizes therapist knowledges as "more stories" of the category of client narratives, rather than reifiying them by alligning them with the laws of human nature.
5. It eschews probablistic and causal analyses, thereby promoting clients' self-determination.
6. It promotes the blossoming of client wisdom by maintaining a tentative, rather than a certain, therapeutic stance.
7. It offers further knowledges to clients to be used as tools for their own meaning making, rather than subverting client understandings by imposing meanings on them[5].
8. It embraces the relevance of therapist knowledges and incorporates both these and client knowledges in a mutual, dialogic, and collaborative process.

Put simply, the notion of cultural wisdom allows us to draw on the knowledges we have accumulated as therapists without trampling on the knowledges of our clients. It is a notion which promotes cultural sensitivity in the broadest sense, as should become clearer in the next section of this essay.

Law-Based Expertise and Racism: Disturbing Parallels

Kiwi Tamasese, Charles Waldegrave and colleagues at The Family Centre in Lower Hutt, New Zealand, through their work with persons of Maori and Samoan as well as European descent, offer a rich account of what can happen when knowledges from one cultural context are assumed to apply to persons from another, subjugated culture: "where understandings of behavior and healing are quite different, the *opposite* [italics added] of healing often occurs. This is

because their places of belonging--their cultures--are displaced in the process" (Tamasese & Waldgrave, 1994, p. 56).

Tamasese and Waldgrave use the term "culture" in the traditional, ethnic sense; but as we have seen, the cultural metaphor effectively captures the contextual imbeddedness of knowledge and its implications for the practice of therapy (Paré, 1996). A "culture" can be seen as a context for meaning making. In that sense, we all inhabit a variety of cultures related to not only ethnicity, but sexual preference and socio-economic class, to name just two other contingenices which help to shape the way we construct our worlds. In their thoughtful exploration of accountable therapeutic practices, Freedman and Combs (1996) draw on examples of these additional cultural groups who, though not "ethnic" in the traditional sense, may construct their worlds differently from the therapist who works with them:

> In therapy, when a man begins to tell us about his relationship and, assuming it to be a heterosexual one, we ask about "her", or when we schedule an initial appointment and, assuming the person has a car, we give directions on how to drive to our office...in all these situations we are shaping the therapy relationship in terms of our own culture and crowding out other possible cultures. (p. 279)

It is not hard to see how we may come to view the knowledges which constitute our "realities" as shared with our clients, and how in doing so, we may actually contribute to the social dynamics that have given rise to the problems they are experiencing in their lives. Freedman and Combs' examples illustrate how this can happen around sexual preference and socio-economic class. We are gratified to observe a growing discourse within family therapy around these disparities, in addition to the usual ethnic diversity addressed by cross-cultural psychology.

It is critical to note that this discussion is not limited to any of the above so-called cultural discrepancies: *all* therapy is cross-cultural--a meeting of knowledges, an exchange of meaning-making practices. To disregard this is to render an intrinsic aspect of the

therapeutic process invisible, and to relinquish responsibility for the consequences of doing so:

> Our secularized concepts of mental health, of individualism and identity, of nuclear family structures and dynamics, of generational boundaries, of "welfare" and child rearing practices, can, to people whose cultures and spirituality are very different from ours, be every bit as unjust and harmful as the shotguns and poisoned waterholes of our ancestors. (Tapping et al., cited in Freedman & Combs, 1996, p. 279)

As practitioners, we are all guilty of cultural oversights in the more conventional sense of the term from time to time; generally speaking I think we are quick to redress these oversights, and to broaden our vision. However, I believe it is more difficult for us to see "clinical expertise" as itself a body of knowledge derived from a cultural context, the culture of "professional psychology/social work", or of "family therapy", for example. These cultures operate according to assumptions and principles that may or may not concur with those of the context at hand--with the clients before us. In other words, we may be "culturally encapsulated" (Ponterotto & Casas, 1991) in our work, regardless of whether we are counselling across ethnic or racial divides.

It is interesting to note that when the meanings of one ethnic culture are privileged over another's, we call it "racism". And yet it is widely accepted practice to privilege law-based, professional assumptions over clients' understandings: we call this "clinical expertise". While our field is beginning to demonstrate a growing awareness of "cultural" issues in the conventional, ethnic sense of the word, we are slower to recognize how aptly the metaphors apply to the unilateral application of rigid, hierarchical professional doctrine and practice. In a very real way, we continue to promote what is in effect "racism" in our lionizing of cross-contextual, law-based knowledges.

Cultural wisdom is about knowledge in practice. It is more than a way of *viewing* knowledges; it also entails a set of practices for introducing those knowledges into therapeutic conversations. A culture-based, idiographic orientation alone does not guarantee that

a therapist will not make unwarranted assumptions, or otherwise engage in relationship practices which are harmful or unethical. Knowledge imparts power, and power is susceptible to exploitation. The responsible conduct of therapy calls for accountability practices to safeguard against the misuse of knowledge--law-based or otherwise.

Accountability Practices

Among postmodern clinical practitioners, and especially those identified with narrative family therapy[6], a number of accountability practices have been introduced to address the issues posed here. Tamasese and her colleagues have developed an exquisite sensitivity to issues of accountability in their work. It is a sensitivity born of a protracted and often arduous process of negotiating around questions of knowledge: its use and abuse (Tamasese & Waldegrave, 1990, 1994). In their multi-racial workplace, they have developed "caucuses" or committees of persons united according to the meaning-making issue at hand in order to address possible misuses of knowledge. A caucus of Maori New Zealanders, for instance, provides feedback to colleagues of European extraction who may inadvertently overlook or misconstrue Maori knowleges in the formation of the agency's policies, or in their cross-cultural clinical work. Callie (1994) describes a similar intra-agency use of caucuses to address her own concerns about heterosexism in the workplace.

Caucuses "highlight the particular concerns of key groups so that their needs are not lost in a compromised partnership" (Tamasese & Waldergrave, 1994, p. 58). The creation of caucuses addresses power disparities by creating a structured format for members of a group marginalized around the issue at hand to share their knowledges and express their values, and to experience the safety that comes from being part of a collective. For example, caucuses may be organized around race, gender, sexual preference, or socio-economic class to provide a forum for addressing grievances and providing feedback.

In effect, caucuses reaffirm a culture-based orientation to knowledge by reminding clinicians that those knowledges they hold sacred in their work may be viewed quite differently by another cultural group, including their clients. Caucuses may be used to promote cross-gender accountability, for example when a male therapist is working with a female client (White, 1995). They may also help to promote accountability in training (Freedman & Combs, 1996; Hall, 1994).

Reflecting teams (Andersen, 1987; Friedman, 1995) provide an alternate means of promoting accountability by inviting a multiplicity of knowledges, and locating those knowledges in personal and professional experience. The reflecting team calls for a public declaration of one's subjectivity, thus countering the possibility that one individuals' view, forged in a cultural context, might fossilize into a sort of law-based "truth" which closes down conversation.

Because of their demands on clinicians' time, the formation of caucuses or reflecting teams is not always viable in some settings. However there are a variety of other means to promote accountability in therapeutic work. In accordance with this discussion, they are premised on the notion that, as Law and Madigan (1994) put it, "no matter how we act to challenge and attempt to stand aside from culture, we can never fully separate and get outside it." (p. 6).

One approach to acknowledging this dilemma is to lay bare the cultural origins behind the knowledges which inform our work. A posture of "transparency" (Freedman & Combs, 1996; Freeman & Lobovits, 1993; White, 1995), wherein the therapist openly shares his/her values and wonderings with clients, helps to keep visible the contextual nature of taken-for-granted knowledges and beliefs. These include ideological stances on issues of enduring relvance to therapy, such as sexual and physical abuse, gender roles, involuntary hospital commitment, and so on. As White (1994) reminds us, therapy is not an island away from ideology, but is immersed, like all of our activities, in our cultural contexts.

Madigan (1993) proposes a variation on transparency by placing a "listening therapist" in the room to punctuate the session with questions directed at the primary therapist. These questions are designed to uncover the origins of the therapist's interactions with clients. As Madigan points out, we continue to perpetuate the myth of therapist expertise even with a posture of "therapeutic curiousity" if that curiousity is solely directed at the contingencies which constrain our clients, without similar attention to those which constrain us. Another way to put this: when we deconstruct our *clients'* experience while presenting *our own* as though it is context-free, we inadvertently ascribe truth status to our knowledges--we say, in effect, that *their* knowledge will get on track with ours once we get a handle on what derailed them along the way.

Griffith and Griffith (1992) promote accountability by ensuring that the language they use--in whatever context--is accessible to clients and not characterized by exclusionary professional jargon. This includes not only therapeutic conversations, but notes, charts, letters, and so on, which they argue should happen in "language that the family members would find affiliative if they were to hear it or read it" (p. 9).

Accountability is something that can be built into practice by adopting a tentative stance reinforcing the absence of fixed laws underlying our knowledges. White (1995) reminds clients that the work is constantly open to revision by checking with them on a regular basis: "I consult them about how the conversation is going for them, about how they see its direction fitting or not fitting with the overall project, about how it is affecting them both emotionally and otherwise, and so on" (p. 169). White says this is not only appropriate, but particularly important in working with children--a "cultural" group in the broad sense whom we are often quick to colonize with adult knowledges.

In my own work, therapeutic conversations are sprinkled with acknowledgements that the knowledges I bring forward may be useful additions to a client's cultural meanings, or they may not weather cultural transplantation well, and may thus be ill-suited to addressing the problem at hand. I do this through the use of

qualifying phrases such as "I've noticed that some research studies show that for many people, the experience you describe leads to X...does that fit for you?"; "Therapists sometimes use the word [some familiar clinical term] to describe what you're going through. Is it helpful to describe it that way, or do you prefer some other description?"; "The reason I'm asking you these questions now might be related to [something about my own professional experience or personal context which I describe to the client]".

The variation of these questions and statements are endless; they are informed not be technique, but by an ethic of relationship--a set of beliefs about what constitutes a respectful conversation. I try to work in a manner less like the colonist bearing spiritual truth (eg. the bible) and technological progress (eg. tractors), and more like the visitor landing on a foreign shore with a boatful of books and artifacts available for perusal or loan. My contact with the locals is equally predicated on drawing upon their own knowledges, so that our relationship is collaboratively determined.

Craig Smith (personal communication, June 28, 1996) makes this negotiation for the direction of therapy an ongoing feature of his work, pointing out that even to ask "would it be helpful to do X?" may still leave clients with a sense of needing to submit to or please the therapist. Instead, Smith tries to propose a range of options for clients to choose from, or to reject, as he and his clients co-create the session.

One approach to balancing the inequity between "therapist as helper" and "client as helped" is to engage clients as consultants to the work of therapy. Their detailed accounts of their successes are made available to other persons dealing with similar issues (Epston & White, 1992b; Parry and Doan,1994):

> Therapy is concluded with an invitation to persons to attend a special meeting with the therapist so that the knowledges that have been ressurrected and/or generated in therapy can be documented. These knowledges will include those alternative and preferred knowledges about self, others, and relationships, and those knowledges or problem-solving that have enabled persons to liberate their lives. (Epston & White, 1992b, p. 17)

This is never a perfect process. But it begins to mirror what Yeatman (1995) refers to in her call for an "ethos of participative service-delivery" (p. 78). This approach is perhaps mostly grandly realized in David Epston's innovation of forming "leagues" of persons to share their personal experience in combatting anorexia and bulimia (Madigan & Epston,1995). Members of Anti-Anorexia and Bulimia leagues, to cite one prominent example[7] are seen as the experts on these problems because they have been actively engaged in resisting their influence in their personal lives.

Epston and Madigan invite women and men who are fighting anorexia and bulimia to pool their knowledges with other league members--mostly clients dealing with these problems, but also therapists, family members, friends, teachers, journalists, and community activists (Madigan & Epston, 1995). The leagues' archives are composed of written transcripts, audiotapes or videotapes of sessions, written testimonials, and other documents which are exchanged amongst league members, and shared by other leagues around the world, all of whom constitute "communities of concern".

In terms much reminiscent of Yeatman's, league members are viewed as "co-researchers" whose experience is generally granted primacy when it comes down to a difference between professional and personal knowledges (Epston, personal communication, May 7, 1996). But the formation of leagues does not imply that the status of "expert" is simply transferred from professional to client, so that one body of knowledge excludes another. In matters where anorexia is particularly tenacious, Epston persistently brings forward medical knowledge indicating a life is at risk, despite a client's dismissal of the seriousness of the situation (Epston, 1993). This approach therefore privileges local knowledge--the cultural understandings of the client--while inviting in the knowledges of others directly dealing with the influence of anorexia and bulimia, and of professionals who are monitoring physical symptoms.

Accountability practices share a commitment to establishing a respectful balance between the knowledges of clients and therapists. In many cases, they involve the introduction of structures to ensure

that power imbalances do not lead to the inadvertent suppression of one group of knowledges (ie. the clients') by another (ie. the therapist's). These practices contrast in many ways from those of traditional science. As I have described, scientific, law-based practice frequently manifests as a colonizing force more intent on converting others to its "truth" than drawing forth "alternative knowledges" (White & Epston, 1992). A re-evaluation of the role of knowledges in psychotherapy involves more than mere reflection--it calls for a shift in relationship, and a redefinition of the task of therapy: "rather than to instruct or provide expert knowledge for clients, the role of the therapist is to enter the social space where meaning is shaped and support the development of alternative meanings to oppressive stories" (Lobovits, Maisel, & Freedman, 1995, p. 224).

Implications for Training/Supervision

It should be clear that these ideas have signficant implications for counsellor training and supervision--activities typically viewed as involving the imparting of "knowledge". In my view, training/supervision and therapy are isomorphic: the issues wrestled with in some detail throughout this essay apply equally to both areas.

An approach to training and supervision informed by cultural wisdom would downplay nomothetic description, except in areas most clearly associated with biology: biochemistry, neuroanatomy, etc. In a manner congruent with the description of a therapeutic posture here, trainers/supervisors would maintain a tentative, curious stance. Trainees/supervisees would be exposed to a wide range of case studies (Polkinghorne, 1994) which serve as exemplars rather than prototypes of rigidly defined categories, and reflecting teams would provide a key component of educatior-student interactions (Freedman & Combs, 1996; Friedman, 1995).

A counsellor education program devoted more to particulars than generalities would strive for the co-creation of knowledges, a collaborative endeavour between educators and students which neither refies academic knowledges nor dismisses those knowledges

by deferring to the knowledges of students. Within this frame, knowledge is seen not as the mirror of nature (Rorty, 1979) or representation of truth, but as contextually imbedded stories with the power to hurt, and the power to heal. Professional ethics become far more than a licensing consideration; they are regarded as absolutely central to the task of therapy itself (Freedman & Combs, 1996)[8].

Summary

This essay attempts the delicate task of establishing a balancing point for the therapeutic exchange. Given the structural inequities of the therapeutic relationship, it is perhaps not surprising that that meeting of knowledges has been dominated by psychotherapeutic approaches which priviledge the knowledge of the clinician. I believe those expert-oriented traditions have more recently given rise to ideas and practices which, through their earnestness to redress this inequity, swing the balance overly far in the other direction. In this discussion, I have attempted to identify some ideas and practices which create space for more of a mutual exchange between therapist and client--a respectful conversation, a genuine dialogue.

This does not come without its challenges. To engage in genuine dialogue, we must be willing to dwell in what Gurevitch (1989) calls "not understanding"--to view the other person as a "legitimate other" who makes meaning in a unique manner. This posture, says Gurevitch, "threatens to disintegrate a former self, which has been been securely encrusted around some conviction, justification, identity, cause, or the like" (p. 165).

That encrustation of which Gurevitch speaks, born of certainty, is a shield against others. Weingarten (1991) would say it stands in the way of intimacy, because it rules out truly shared meaning-making. It also blinds us to the potentially negative impact of our work:

> If our work has to do with the idea of subjecting persons to 'truth', then this renders invisible to us the consequences of how we speak to people about their lives, and of how we

> structure our interactions with them; this mantle of 'truth' makes it possible for us to avoid reflecting on the implications of our constructions and our therapeutic interactions in regard to the shaping of people's lives. (White, 1995, p. 115)

There is a certain comfort that comes with believing we are bearers of truth. It helps to stabilize the vertigo of ambiguity, gives us a sense of control, and protects us from the prospect of attending to those ways in which we purposely or inadvertently abuse our power in our relationships with others. The commitment to find a greater balance between self and others is not made lightly. "Even when this commitment is there," writes Maclean (1994), "the problems associated with communication across cultural and power-divides will almost inevitably involve painful self-examination" (p. 31).

However, as I have tried to articulate throughout this essay, I do not believe the appropriate response to previous imbalances is to merely swing the weight over to the client's side. Without a healthy respect for our own experiences, including an accumulation of clinical narratives, we do not meet our clients as whole persons. We cannot help but to bring our own preunderstandings to each therapeutic encounter--knowledges which themselves emerge from the cultures we inhabit. "We are never alone with the persons who come to see us in our office", writes Madigan (1996, p. 54), which is to say that the meaning-making that both we and our clients engage in are situated in historical and social contexts. To attempt to exclude *our* knowledge from the therapeutic conversation is to deny this shared aspect of our meaning-making, and might even be seen as a denial of our shared humanity.

It is our own knowledge which guides us to identify and feel compassion for another's pain, or that prompts us to ask more about something a client has done which has lessened that pain, or transformed it. Even when we are guided by a posture of curiousity, we rely on our experience to *direct* that curiousity. It is the knowledge we bring which guides us in attending to some details and overlooking others in a client's story. Owning one's knowledge and exploiting it are two different things: it is how we characterize our

knowledge, and how we invite it into the therapeutic encounter, that distinguishes cultural wisdom from law-based expertise.

Footnotes

1. The word "knowledge" is pluralized at times throught this essay to emphasize the many contexts from which knowledge emerges, and to avoid depicting knowledge in terms of unitary truth.

2. Kuhn (1970) points out how science rests upon a set of founding beliefs and assumptions. This constantly evolving "paradigm" does not necessarily reflect the beliefs and assumptions of the general culture, even among the technologically advanced nations. In effect, it is an ever-changing story emerging from a specific culture--the culture of the scientific community.

3. It is also possible to see this meeting as occasionally involving many more cultures: the cultures of men and women, of children and adults, of middle class and working class, etcetera (cf. Paré, 1996a). For simplicity sake, the culture metaphor is here being used to delineate the culture of the client(s) and the culture of the therapist.

4. Within therapy circles, the term "clinical wisdom" is sometimes used to depict the knowledge upon which interventions are founded. I deliberately avoid the term here because as often as not it is associated with nomothetic, or law-based knowledges. Cultural wisdom is narratively oriented, pragmatic, and idiographic.

5. Alan Wade's work (1996, June) is one of myriad examples of how therapists may offer alternative descriptions that clients may adopt to liberate themselves from oppressive meanings. He helps those who have been sexually abused to discover how they did not merely "survive", but actively resisted the abuse.

6. "Narrative" has become an organizing framework for a wide assortment of disciplines and sub-disciplines within the human

sciences. "Narrative family therapy" is typically identified with the seminal work of Michael White and David Epston (Epston & White, 1992; White, 1993, 1995; White & Epston, 1990).

7. David Epston formed the first such league in New Zealand. A second Anti-Anorexia and Bulimia League, intiated by Stephen Madigan, now flourishes in Vancouver. As well, a number of other leagues are being formed worldwide to counter the influence of other problems, such as "temper" (c.f. Freeman & Lobovits, 1993) and depression.

8. For a more in-depth look at counsellor training and supervision from a postmodern perspective, see the special issue of the Journal of Systemic Therapies, 14(2), 1995.

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Table 4-1
Distinguishing Features of Law-Based versus Culture-Based Views of Knowledge

Law-Based Knowledge	Culture-Based Knowledge
Generalized	Particularized
Cross-contextual	Context-specific
Hypothetico-scientific	Historical/narrative
Reductionistic	Holistic
Clinical expertise	Cultural wisdom
Prototype	Exemplar
Theoretical	Practical
Rule-based	Case-based
Hierarchical	Collaborative
Certainty	Curiosity
Prediction and Control	Insight and Understanding

CHAPTER FIVE:

Afterword

The essays assembled here articulate, from a variety of perspectives, an emerging movement in psychology and psychotherapy informed by postmodern ideas and practices. For me, the experiencing of engaging in the research and writing enclosed between these covers has been a journey into always fascinating, and often moving, territory. I believe psychotherapy is now crossing the threshold of an exhilarating new era.

It is not the first time the field has been in this place: I can think of the furor accompanying the introduction of Freud's curious new talking cure, the technological promise of Skinner's behavioral advances, the humanistic pledge of Rogers and Maslow; the ecological scope of Bateson's systemic view.

But this threshold seems different to me. Whereas psychology has often been filled with a sense of expansiveness over its apparent power to understand and control human behavior, it is now being humbled as it gazes upon the breathtaking multiplicity of human experience. This era seems different from all the rest because it is not merely talking about different experiences, it represents a re-visioning of experience itself. The essays gathered here are attempts to articulate aspects of that emerging vision. The project ahead involves extending the vision and incorporating it into not only professional language, but the everyday lexicon.

The first paper, *Us and Them: Therapist Talk and Other Dividing Practices,* presents a critique of the manner in which we have come to classify persons relative to each other, and against arbitrary standards of health. It makes a strong case for the beauty and worth of our uniqueness, but does not describe an alternative to

the DSM for practitioners seeking a shared language for speaking about their clients and the problems they face. Tomm (1991) is engaged in this work; much more needs to be done.

We need a way of talking about problems in non-essential terms--perhaps by reference to the ways in which they stand between intention and outcome of actions, rather than by reference to some mythical and objective standard of mental health. We also need to devise collaborative means of assessment that do not involve the expert on the outside looking in at the object of study, the client. It is hard to say what these changes will look like. In a sense, I am talking about a classification system for a paradigm bent on debunking classification systems. We cannot look to science for the answer; we will have to will have to rely on the hard-earned understandings we have acquired in re-thinking our world.

The second paper, *Intentions gone awry: Using a narrative metaphor with persons who abuse,* leads into what for me is fascinating territory. It dares to ask "What does therapy look like when we act as though we are free?" In my opinion, the answer is that we begin to work with persons in a way that is truly respectful, because we honour their power to effect changes in their lives. It also leads to a clarity that is lost in approaches which demand agency on the part of clients while utilizing techniques which reflect a deterministic vision.

I am very curious to explore where these ideas lead us when they are applied with equal vigor to clients who come to therapy with issues unrelated to their abusive ways. Because persons who abuse are seen to have acted in undesirable ways, it makes sense to

focus on them as "actors" who have chosen the problem they are concerned with resolving. I think it is more difficult to work with these metaphors when a person reports with, for example, depression or anxiety. The narrative work I am familiar with tends to locate the problem outside the person, which fits the theoretical frame discussed here. But there is a ring of the notion that they have been "victimized" by oppressive stories, which is not quite the same as the idea that they have chosen and are continuing to choose those oppressive stories--stories which are sapping their energy and their hope.

To say they have chosen their feelings of sadness, lethargy and hopelessness makes good theoretical sense in light of the arguments laboriously detailed in the second paper here. But handled poorly, this pronouncement may sound strikingly uncompassionate and harsh. Nevertheless, I believe there are great possibilities for construing complaints like depression or anxiety in terms of a misalignment between the client's intentions and the circumstances they have chosen. I think the degree to which we downplay the choice they own is probably the degree to which we downplay their power to enact changes in their lives. As the narrative metaphor becomes more widely experimented with, I am certain refinements will be introduced which enable us to stay true to the metaphor while engaging with all sorts of clients in a mutually respectful and collaborative process.

The third paper here, *Cultural Wisdom: Reflections on Knowledge and Accountability in Postmodern Clinical Practice,* appears to me like a first, hesitant move of my own theoretical

pendulum back towards the centre following several years of heady absorption in narrative ideas. The paper articulates what I might call "narrative orthodoxy" in its critique of colonial practices and its call for accountability. But it is also intent on reclaiming some of what postmodern psychology seems determined to throw out.

In developmental terms, one might say I have differentiated sufficiently from modernist practices that I can now meet them as an equal, and appreciate their positive qualities side by side with their less savory aspects. I have come to this place largely through my practice. As I pay attention to my experience in the act of engaging in therapeutic conversations, I notice much that I am at a loss to describe in postmodern or narrative terms. There are very many ways to characterize this family of experiences. I am currently working on a presentation about what I call *narrative stability,* which explores these ideas.

The ideas are premised on the notion that when we view knowledge as socially constructed (a cornerstone of the narrative worldview), then it makes sense to consider knowledge as having a sort of "stability" beyond the conversation at hand. You may say the Holocaust never happened and I may agree with you. We might even exercise unfathomable persuasion in order to have the concentration camp still standing at Auschwitz leveled and planted over with flower beds. But we cannot erase the "reality" of the Holocaust; it will continue to live in the minds of millions upon millions of survivors, their offspring and contemporaries. The narrative paradigm steers away from conceptions of "truth", but there is a certain weightiness to widely diffused cultural narratives

that gives them an authority which is something akin to "truth" in the modernist sense.

One possible direction prompted by the third paper, then, is an examination of this notion of "narrative stability" and the places to which it leads in the practice of psychotherapy. I have begun that examination, and am discovering that it opens up into a wide territory hitherto unexplored in narrative terms. I see the project ahead as the re-interpretation and re-languaging of a vast body of understandings premised on modernist assumptions: a sort of reclaiming of our world, a writhing free of science's totalizing grip.

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